WELFARE REFORM: A REVIEW OF ABSTINENCE EDUCATION AND TRANSITIONAL MEDICAL ASSISTANCE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

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WELFARE REFORM: A REVIEW OF ABSTINENCE EDUCATION AND TRANSITIONAL MEDICAL ASSISTANCE

TUESDAY, APRIL 23, 2002

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to notice, at 3 p.m., in room 2322, Rayburn House Office Building, Hon. Michael Bilirakis presiding.

Members present: Representatives Bilirakis, Upton, Greenwood, Norwood, Buyer, Pitts, Tauzin (ex officio), Brown, Waxman, Strickland, Barrett, Hall, Stupak and Green.

Also present: Representative Harman.

Staff present: Erin Kuhls, majority counsel; Steven Tilton, health policy coordinator; Eugenie Edwards, legislative clerk; Amy Hall, minority professional staff member, John Ford, minority counsel; Bridgett Taylor, minority professional staff member; Karen Folk, minority professional staff member; and Jessica McNiece, staff assistant.

Mr. BILIRAKIS. I now call to order this hearing of the Health Subcommittee and would like to thank our witnesses for taking the time to appear before us today and I feel sure that your testimony will prove valuable as we consider reauthorizing our Nation's welfare laws.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 reformed our Nation's welfare laws to put an emphasis on work and end the seemingly endless cycle of dependence that was present under the old Aid to Families with Dependent Children program.

The Health Subcommittee has jurisdiction over two areas of this landmark legislation which will be the focus of today's hearing. The issues that we're considering today are accurately captured, I feel, by the title of the 1996 law. Personal responsibility is encompassed by the funding provided to Title V of the Social Security Act related to abstinence only education. Title V allocated $50 million for fiscal years 1998 to 2002 for block grants to States for development of abstinence only education programs. To date, 49 of the 50 States have elected to participate in this program and I think this suggests that States have a high interest in abstinence only education programs.

I'm very pleased that my own Satte of Florida has elected to participate in this program. In fact, today we will hear from Jac-

queline Del Rosario who will provide our subcommittee with valuable real world and I underline real world data on Florida's experience. So often up here in Washington we don't have the opportunity to hear from experts like Ms. Del Rosario who have real world exposure. Again, I welcome you particularly Ms. Del Rosario. I'm anxious to hear more about the near 100 percent success that your program has achieved with respect to limiting teen pregnancy rates.

Transitional medical assistance is the second component, God knows, a very significant one the 1996 law that is under this subcommittee's jurisdiction. As we all know, the costs of health insurance continue to rise. Many low income individuals who move from welfare to work often take low wage jobs that do not offer private health insurance coverage. Transitional medical assistance extends Medicaid coverage to these former welfare recipients for up to 1 year after they leave the rolls. Obviously, the potential loss of one's health insurance would be a significant disincentive to leaving welfare and entering the work force. Transitional medical assistance removes this barrier and ensures people do not have to sacrifice their health care in order to enter the work force.

I would like to again thank our witnesses for appearing before us today and now I'm pleased to recognize the ranking member, Mr. Brown, for his opening statement.

Mr. BROWN. Thank you, Mr. Chairman, I want to welcome our witnesses, thank you for joining us today.

Although there's no funding for the transitional medical assistance program in the Republican budget blueprint, reauthorization of this program isn't or shouldn't be a partisan issue. I appreciate your willingness, Mr. Chairman, and Chairman Tauzin's willingness to focus on TMA this afternoon.

The President's budget includes funding for 1-year extension of TMA because to quote their budget document "this coverage helps ensure the work pays for families by preventing them from losing their health coverage when they start jobs." Well put, but actually, the fundamental goal of welfare to work is not to increase the number of individuals who enter the workplace, it's to increase the number of individuals who stay in the workplace. Employers who have hired welfare recipients have stated that access to help insurance is one of the five most important factors that keep those workers on the job. The TMA program makes sense. There are steps we can take to strengthen and improve the program that also makes sense.

TANF has a 5-year authorization. TMA should be a 5-year authorization too. TMA is weighed down by some counter-productive regulatory requirements. I know how much my friends on the other side of the aisle hate government regulations. Here's a golden opportunity to eliminate some of them.

Let me give one example. Even though TMA recipients are eligible for 6 months regardless of income, these recipients must periodically go to the welfare office to report their income so individuals who are newly employed must take several days off from work to report information irrelevant, really irrelevant to their TMA eligibility or they will lose their TMA eligibility. We need to do some-

thing about that and other needless hurdles that compromise the reach and the effectiveness of the program.

There's another logical step that we can take. We can restore Medicaid eligibility to legal immigrants, banning legal immigrant families, families that work here, pay taxes here just like all of us in this room, banning legal immigrant families from the Medicaid program is unfair, it's arbitrary and it's foolish. Reducing the number of uninsured is a bipartisan goal. You can search high and low and not find a more effective way to contravene that goal than by excluding legal immigrants from Medicaid. Immigrants are more than twice as likely to be uninsured as non-immigrants. Our colleagues, Mr. Waxman and Mr. Diaz-Balart, have introduced legislation, H.R. 1143 which would remove that Medicaid ban. If we took no other action this year to expand insurance coverage, we should at least retrace our footsteps and incorporate H.R. 1143 into this year's TANF reauthorization.

I want to turn to the other topic of this afternoon's agenda, abstinence only education. The key word is "only." I doubt there is any parent or policymaker who opposes featuring abstinence as a critically important component of sex education. We know for a fact that very few parents favor abstinence only education. A recent poll shows that 90 percent of parents with adolescents at home want their child's sex education program to cover both abstinence and general information covering topics like birth control. Yet, if a State wants to use Federal tax dollars to provide sex education it must agree to use an abstinence only curriculum. There appears to be a major disconnect. And I have to say it's ironic that we're considering Medicaid and abstinence only education in the same hearing. The administration, the Republican majority are generally very supportive of State flexibility. That's nowhere more apparent than in Medicaid. Look for the fine print in the Medicaid flexibility waivers. There really isn't any. These waivers and the President's Rx drug waivers are a hair's breath away from the blank check. But when it comes to any issue like abstinence only education, it's somehow Okay for this administration, it's okay for the Federal Government to put a chokehold on the States. It's a Federal State matching program with a curriculum wholly dictated by the Federal Government. So sometimes we want States' rights, other times when it doesn't serve our purpose, we don't.

To protect our kids and respect their parents' wishes, States should be able to use this funding to promote abstinence in the context of real world choices and implications.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. Mr. Upton, for an opening statement.

Mr. UPTON. Well, thank you, Mr. Chairman, for convening this hearing. As a lead sponsor of H.R. 4122, legislation reauthorizing these programs, I'm very pleased that we're moving in a very timely manner to reauthorize these vital components of the 1996 Welfare Reform Bill.

Anyone who doesn't think abstinence education works has only to examine the Michigan record. Begun in 1993, Michigan's Abstinence Program, MAP, is an innovative approach implemented through the community empowerment model. Community coali-

tions plan, implement, evaluate, revise, and monitor the program. It works. For the last 3 years in a row, Michigan has received a bonus award from the Department of HHS given each year to up to five States which experience the largest decrease in their ratio of out-of-wedlock to total births, while also experiencing a reduction in their abortion rate.

Too many of our children's dreams have been cut short by bad decisions that dramatically alter the course of their lives. Abstinence education programs give our young both the inspiration and education that they need to make good, healthful decision. Our young people look to us for clear messages and for help in setting high standards for themselves. Abstinence education programs will give them that help, that is for sure.

It is also vital that we reauthorize the TMA, Transition Medical Assistance Program. One of the greatest disincentives to leaving the welfare rolls and entering the workforce is the loss of Medicaid coverage, particularly for children. It is important that we ensure that former welfare recipients and their families do not abruptly lose their coverage. This legislation, H.R. 4122, extends that vital program for another year. We look forward to today's hearing and we look forward to working with the chairman and I yield back the balance of my time.

[The prepared statement of Hon. Fred Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman, thank you for convening today's hearing to review the Abstinence Education and Transitional Medical Assistance programs. As the lead sponsor of H.R. 4122, legislation reauthorizing these programs, I am very pleased that we are moving in a timely manner to reauthorize these vital components of the 1996 welfare reform bill.

Anyone who doesn't think abstinence education works has only to examine the Michigan record. Begun in 1993, Michigan's Abstinence Partnership (MAP) program is an innovative approach implemented through the community empowerment model. Community coalitions plan, implement, evaluate, revise and monitor the program. Parent education is provided to encourage effective communication with youth about the importance and benefits of choosing abstinence. For the last three years in a row, Michigan has received a bonus award from the Department of Health and Human Services given each year to up to five states which experience the largest decrease in their ratio of out-of-wedlock to total births, while also experiencing a reduction in their abortion rate.

And Michigan is far from alone in embracing abstinence education as an effective means of reducing teen pregnancies and out-of-wedlock births and of protecting our young people from the scourge of sexually transmitted diseases. State participation in the Title V abstinence education program is voluntary, and for every four dollars in federal funding states receive, they must put in three dollars in non-federal funding. Yet interest in this program is high. Today, 49 out of the 50 states are participating in the program, and over one-third of all school districts in the nation now choose to teach abstinence education in their classrooms. As part of their abstinence education programs, states and local grantees have launched media campaigns to influence attitudes and behavior, developed abstinence curricula, revamped sexual education classes, started mentoring programs, and implemented many other creative and effective approaches to encourage abstinence.

It is important to note that reauthorizing the Title V Abstinence Education program will in no way affect federal support for other teen pregnancy prevention/sexual education programs. There are at least 25 federal programs providing funding for contraceptive/sex education, while there are only 3 abstinence-focused programs. Contrary to claims that you may have heard about restrictions on what may be discussed in abstinence education programs, nothing in the federal law or guidelines to the states prohibits the discussion of *any* subject. And contrary to the claim that there is no scientific evidence that abstinence programs work, there are in fact ten

scientific evaluations available showing that abstinence education is effective in reducing early sexual activity.

Since the 1996 enactment of welfare reform including abstinence education, teen pregnancy and birthrates have been falling. That is good news, but we need to continue and build on this success. Out-of-wedlock births are often disastrous for mothers, children, and society as a whole. Children born out of wedlock are far more likely to be poor, suffer ill health, drop out of school, and in the case of boys, are twice as likely to commit a crime leading to incarceration by the time they reach their early thirties.

Sexually transmitted diseases (STDs) have reached epidemic proportions in our country, placing the health and lives of sexually active young people in serious peril. In the 1960s, one in 47 sexually active teenagers was infected with an STD. *Today, one in four is infected.* Young people need to know that having sexual relations puts them at risk not only for HIV/AIDS, but also herpes, which is incurable and may infect babies during birth resulting in severe damage or death. Teens need to know that they are at risk for Human Papillomavirus (HPV), which is the leading viral STD and which causes nearly all cases of cervical cancer. And they need to know that scientific research shows that condom use offers relatively little protection from herpes and no protection from HPV. Abstinence education programs provide this information.

Too many of our children's dreams have been cut short by poor decisions that dramatically alter the course of their lives. Abstinence education programs give our young people both the inspiration and education they need to make good, healthful decisions. Our young people look to us for clear messages and for help in setting high standards for themselves. Abstinence education programs will give them that help.

It is also vital that we reauthorize Transitional Medical Assistance. One of the greatest disincentives to leaving the welfare rolls and entering the workforce is the loss of Medicaid coverage, particularly for children. It is important we ensure that former welfare recipients and their families do not abruptly lose their coverage. H.R. 4122 extends this vital program for one year.

I look forward to today's hearing and to moving to a full Committee markup on these two important parts of welfare reform.

Mr. BILIRAKIS. The Chair thanks the gentleman. Mr. Waxman, for an opening statement.

Mr. WAXMAN. I think Mr. Hall is here before me.

Mr. BILIRAKIS. Were you here when the gavel went down?

Mr. WAXMAN. No, I wasn't.

Mr. BILIRAKIS. Mr. Hall for an opening statement.

Mr. HALL. Mr. Waxman got up here before I did, by many years.

Mr. WAXMAN. You're a fine, young man.

Mr. HALL. And I'd be glad to follow Mr. Waxman any time.

Mr. Chairman, I want to thank you for bringing this before the subcommittee, these bills, abstinence education and transitional Medicaid assistance, both of which, I think, are critically important to providing critical health care need for the most vulnerable of our country.

I'm pleased to be the Democratic co-sponsor of both reauthorizations and I hope there will be bipartisan support for their passage. The abstinence education bill is simply reauthorization of Title V funding to promote adolescent health, prevent teen pregnancy and reduce sexually transmitted diseases by stressing abstinence. Teaching our children to abstain from sexual activity is one absolute way to prevent pregnancy. Of course, there are others. Unfortunately, some people feel that this legislation threatens family planning and contraceptive programs. Although I might be willing to threaten family planning and contraceptive programs, this bill doesn't do it.

These Title V funds do not impact other family planning programs and are not mutually exclusive of other sex education meth-

ods. Funding abstinence education simply expands the options our communities will have at their disposal to help reduce teenage pregnancy. We're all in agreement that teenage out-of-wedlock pregnancies is a problem that we have to address. Why then do we want to prevent our communities from gaining access to this important tool?

Mr. Chairman, a vote against providing a meager $50 million for abstinence education isn't bolstering family planing and contraceptive sex education methods. It's a vote against a complementary tool in protecting our teens.

The other piece of legislation I've co-sponsored is the reauthorization of transitional Medicaid assistance. This program extends Medicaid benefits for 1 year to those people who are succeeding in removing themselves from the welfare roles. Many poor and near poor families cannot afford their own health insurance, even if they are working, yet they may not qualify for Medicaid in some States. By bridging this gap, this helps families to stay off of welfare. I hope both my Democratic and Republican colleagues will join me in supporting these two important critical reauthorizations. Both have proven effective in the past and I believe it could be a devastating shock to our community should these programs disappear.

I yield back my time.

Mr. BILIRAKIS. Thank you. Dr. Norwood, for an opening statement.

Mr. NORWOOD. Thank you, Mr. Chairman. I'm anxious to hear from our witnesses and with that I would ask permission to put my statement in the record and thank you for having the hearing.

Mr. BILIRAKIS. Without objection, the opening statement of all members of the subcommittee will be made a part of the record.

Let's see, Mr. Waxman, for an opening statement.

Mr. WAXMAN. Thank you very much, Mr. Chairman. Unfortunately, this committee has chosen to limit this hearing today to only some of the areas in this committee's jurisdiction which are part of welfare reform. We're looking at transitional Medicaid assistance for people leaving the welfare rolls for work and we're looking at the abstinence education program established in the Welfare Reform Law of 1996. But the Majority is studiously ignoring the ban on Medicaid coverage for legal immigrant children and pregnant women that resulted from the anti-immigrant provisions that were forced through this Congress in 1996, under the guise of reforming the welfare system. That policy was wrong then and it's wrong now. Banning coverage of legal, immigrant children and pregnant women for 5 years after entering the country and continuing to attribute the sponsor's income to the near permanent barrier occurs is worse than simply short-sighted health policy. It is a perverse and insidious discrimination against legal immigrants who work and pay taxes. It risks long-term health effects on children born without prenatal care. It undermines efforts for broad participation of children in the Medicaid and the SCHIP programs. And we're not just ignoring the topic in today's hearing, the limited, narrowly drawn mark-up vehicle the committee will consider tomorrow is obviously designed to block members from having any opportunity to redress this wrong. Some might even conclude that this is clearly an effort to protect members from voting on this

issue. Better to discriminate in the dark than vote directly on this mean-spirited policy.

I conclude that this is an intentional action in response to the wishes of this administration. It leaves legal immigrant children and pregnant women without health care and it leaves States holding the bag. If they want to provide coverage, as many do, they have no Federal matching assistance. It is ironic indeed that this administration which seems willing to waive just about any requirement of Medicaid law has refused to use its waiver authority to allow States to cover legal immigrant women and children and now has also blocked consideration of legislation to remedy this.

This decision denies our colleague representative, Lincoln Diaz-Balart, the lead sponsor of H.R. 1143, the Legal Immigrant Children's Improvement Act and the 118 bipartisan co-sponsors who have joined us on the bill the opportunity to vote on remedying this policy. This is the right time to end that discrimination and this is the right mark-up to take action on that legislation. It is doubly ironic that instead, we're focusing on continuing a program of abstinence education that has very little to do with good health policy, but a lot to do with the political agenda.

Let's be clear. No one is against abstinence. No one is dismissing the advantages of abstinence, particularly to young people who are not yet mature enough to make important life choices. No one is against educating young people about the advantages of abstinence, but it is a ridiculous policy to pretend that people, including young people, will not be sexually active whatever we may tell them. They need to know how to protect themselves from unwanted pregnancies and from transmission of sexually transmitted diseases and HIV. This knowledge can literally be the difference between life and death.

A program that purports to be about public health, but which does not allow open and complete communication on all the ways of avoiding unwanted pregnancies and transmission of sexually transmitted diseases and HIV is not just a poor program, but a harmful program. A gag rule on information is no way to solve a serious public health problem and I'm pleased that our colleague, Congresswoman Harman, will be offering some amendments on this subject. I hope we can get bipartisan support.

In closing, let me note that the Transitional Medical Assistance Program which is also being considered today is a vital part of any successful effort to move people off welfare and into the work force. I believe this program has broad support on both sides of the aisle. In view of that, it is particularly regrettable that the legislation before the committee tomorrow is limited to a 1-year extension of Transitional Medical Assistance. Obviously, it takes much more—it would make much more sense to reauthorize this program for the full period of reauthorizatoin of TANF. I hope my colleagues on the committee would recognize the clear advantage of that and will——

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. WAXMAN. Just to complete the sentence. That presents itself on the floor or in conference to achieve that result.

Mr. BILIRAKIS. The Chair recognizes the chairman of the full committee, Mr. Tauzin, for an opening statement.

Chairman TAUZIN. Thank you, Mr. Chairman. I want to thank you for holding this very important hearing. Reauthorization of the landmark 1996 Welfare Reform Law is an important priority for Congress this year. In the next few weeks, in fact, we will be undertaking this very worthy task and the hearing and the testimony that this panel will provide today will help us in that effort. I want to thank you for coming and sharing with us today.

We're focusing on two welfare reform issues within the committee's jurisdiction—abstinence only education and transitional medical assistance. I understand there are differences of opinion regarding one of these issues, which I expect will produce a healthy bit of debate today. Back in 1996, Congress passed, and President Clinton signed into law, welfare reform legislation. This law included a permanent appropriation of $50 million over 5 years for abstinence only education. Almost every State has participated in this State block grant program voluntarily. To do so, they have to match every $4 Federal with $3 of their own, which suggests a very high State interest in using abstinence only education as one way to address teen pregnancy. We've seen an incredible reduction in the rates of teen pregnancy in this country and, more importantly, a huge reduction in the number of children living under poverty. Obviously, the program is working and we need to continue it.

In fact, to address the States' high teen birthrates and sexually transmitted disease rates, my own State of Louisiana has applied for and received funding for abstinence only education under Title V. The goals of the Louisiana program are laudable, to reduce teen pregnancy and STD rates by delaying the onset of sexual activity, to decrease risk behaviors and to educate young people concerning the importance of obtaining self-sufficiency and marriage before engaging in sexual activity.

Louisiana has a coordinated state-wide evaluation plan in place to measure the effect of the program in meeting these goals. This important program reaches kids through 10 community based projects that are designed to promote sexual abstinence among adolescents ages 13 through 19. The program also uses public and private schools to get the abstinence message to teens and pre-teens through clubs established in 30 high schools in various school districts across the State, and in seventh grade health classes in various junior high schools in our State.

I look forward to the testimony of Ms. Del Rosario who will speak firsthand about her experience spreading the message of abstinence to at risk teens through her program entitled Recapturing the Vision. Her program strengthens students, providing them with accurate information to promote healthy sexual decisions and behaviors so that these students can build a much brighter future for themselves. I want to thank you for traveling from Florida to be with us today.

We will also hear today testimony from Dr. Joe McIlhaney, who after nearly 30 years of practice as a gynecologist is dedicating himself to addressing two medical problems affecting our Nation's youth, out-of-wedlock pregnancy and sexually transmitted disease issue.

I would also like to thank and welcome Dr. Kaplan, a professor from the University of Colorado, School of Medicine, who has a different perspective through his work as a pediatrician.

This hearing will also focus on an important work support for former welfare recipients, Transitional Medical Assistance. This benefit ensures that former welfare recipients have health care coverage after entering the work force. It is due to expire this year. We all recognize that this assistance provides a valuable incentive for people to move off of welfare. In fact, the President said, if you want to value and measure compassion in the welfare area, it's not on how much we spend on welfare, how many people are on welfare, but how many people we rescue from that system and actually introduce to the world of self-respect and decency, to a world where they're not dependent upon someone else, but they have their own independent life. That is indeed the goal of this hearing today.

Cindy Mann from the Kaiser Commission on Medicaid and the Uninsured and Bill Scanlon from the General Accounting Office are here today to highlight the benefits of Transitional Medical Assistance and we look forward to hearing from them.

Ms. Bilirakis, let me thank you again for holding this important hearing and I yield back the balance of my time.

Mr. BILIRAKIS. I thank the chairman. Mr. Stupak for an opening statement.

Mr. STUPAK. I'll pass, Mr. Chairman.

Mr. BILIRAKIS. Dr. Norwood?

Mr. NORWOOD. I've already passed.

Mr. BILIRAKIS. You've already passed, haven't you. Mr. Pitts.

Mr. PITTS Thank you, Mr. Chairman, for holding this important hearing today. In the 1996 Welfare Reform Law, Congress provided $50 million each year for fiscal year 1998 to 2002 for abstinence only education to help our Nation's young people avoid unplanned pregnancies, sexually transmitted diseases and the emotional consequence of sex outside of marriage. I am pleased that the legislation before us today will reauthorize this program for the next 5 years at $50 million a year.

Mr. Chairman, as we address this issue, we must be aware of the consequences of early sexual activity, the undesirable contents of conventional safe sex educational programs and the findings concerning the effectiveness of genuine abstinence programs. Abstinence education is essential to reducing out-of-wedlock childbearing, preventing sexually transmitted diseases and improving emotional and physical well-being among our Nation's youth. True abstinence education programs help young people to develop an understanding of commitment, fidelity and intimacy that will serve them well as the foundations of healthy marital life in the future. Abstinence education programs have repeatedly been shown to be effective in reducing sexual activity among their participants. In my State of Pennsylvania, abstinence education and related services is a $3.8 million initiative. The Pennsylvania program incorporates local communities in crafting and implementing the abstinence services. It emphasizes the role of parents and guardians in teaching the skills to empower youth to abstain from sexual activities as well as ask the role of health care providers in providing counseling and guidance to teens and their parents.

Pennsylvania also has a strong media component to their abstinence education program in which a television, radio or movie theater campaign encourages parents to talk to their kids about sexual matters. I'm also pleased to report that the Pennsylvania Department of Health is able to use some TANF funds to create an abstinence curriculum targeting Latino youth. While preliminary reports sound promising, I'm looking forward to seeing the final evaluation of the entire project in Pennsylvania when the grant ends in September 2002.

Mr. Chairman, as we review this issue, I think we need to realize that sexually transmitted diseases including incurable viral infections have reached epidemic proportions. Annually, 3 million teenagers contract STDs. STDs afflict roughly 1 in 4 teens who are sexually active. Second, early sexual activity has multiple negative consequences for young people. Research shows that young people who become sexually active are not only vulnerable to STDs, but also likely to experience emotional and psychological injuries, subsequent marital difficulties and involvement in other high risk behaviors. Third, conventional safe sex programs, sometimes erroneously called abstinence plus programs, place little or no emphasis on encourage young people to abstain from early sexual activity. Instead, such programs strongly promote condom use and implicitly condone sexual activity among teens. This is not true abstinence education. And finally, despite claims to the contrary, there are scientific evaluations showing that real abstinence programs can be highly effective in reducing early sexual activity and I would like to ask unanimous consent to submit for the record a summary of these evaluations.

[The material follows:]

[Pitts]
Doc for Record
Health 4-25-02
Sb Hrg

Do Condoms Prevent HPV Infection?

National Institute of Allergy and Infectious Diseases
National Institutes of Health

"For HPV, the Panel concluded that there was no epidemiologic evidence that condom use reduced the risk of HPV infection."

Excerpt from July 20, 2001 "Workshop Summary: Scientific Evidence on Condom Effectiveness for Sexually Transmitted Disease (STD) Prevention" prepared by the National Institute of Allergy and Infectious Diseases

"Condoms are ineffective against HPV because the virus is prevalent not only in mucosal tissue (genitalia) but also on dry skin of the surrounding abdomen and groin, and it can migrate from those areas into the vagina and the cervix. Additional research efforts by NCI on the effectiveness of condoms in preventing HPV transmission are not warranted."

National Cancer Institute

Excerpt from a February 19, 1999 letter to House Commerce Committee Chairman Tom Bliley from Dr. Richard D. Klausner, Director of the National Cancer Institute at the National Institutes of Health

"Recent research shows that condoms ("rubbers") cannot protect against infection with HPV. This is because HPV can be passed from person to person with any skin-to-skin contact with any HPV-infected area of the body, such as skin of the genital or anal area not covered by the condom. The absence of visible warts cannot be used to decide whether caution is warranted, since HPV can be passed on to another person even when there are no visible warts or other symptoms. HPV can be present for years with no symptoms."

Excerpt from the American Cancer Society website (www.cancer.org).

"The data on the use of barrier methods of contraception to prevent the spread of HPV is controversial but does not support this as an effective method of prevention. ... Reducing the rate of HPV infection by encouraging changes in the sexual behavior of young people and/or through developing an effective HPV vaccine would reduce the incidence of this disease."

National Institutes of Health Consensus Development Conference Statement on Cervical Cancer, April 1-3, 1996

EXPAND STORY

Papilloma virus, using Pill tied to cervical cancer risk

Chicago Sun-Times, 03/27/02

LONDON--Women infected with the common sexually transmitted human papilloma virus have a higher risk of developing cervical cancer if they have taken birth control pills for more than five years, new research indicates.

Experts say the study supports what many gynecologists have long suspected--a causal link between the Pill and cervical cancer.

Previous studies have not ruled out the possibility that women who take the Pill may simply be more likely to be infected with HPV, the main cause of the cancer.

"This study suggests that if you've got an HPV infection, oral contraceptives may actually be promoting the rate at which that progresses to cancer," said Dr. Jack Cuzick, head of mathematics, statistics and epidemiology at Cancer Research UK in London. He had no link with the study.

Nearly all sexually active women will be infected by HPV sometime during their lives, but in most cases the immune system quickly eliminates it. The key issue is why, in some cases, the virus does not go away. If the infection persists, the chances of cancer increase enormously.

The study was conducted by the International Agency for Research on Cancer, an arm of the World Health Organization.

WHO researchers found that women who had taken the Pill were no more likely than the others to be carriers of HPV. But those infected with HPV who had used birth control pills for an accumulated total of five years or more were nearly three times more likely to develop cervical cancer than HPV-infected women who had never taken the Pill.

The increased risk persisted for up to 14 years after stopping the contraceptives.

Women who had taken the Pill for 10 years or more were four times more likely to get the disease than those who had never taken it.

Using the Pill for less than five years did not result in a higher chance of cervical cancer.

Cervical cancer strikes 12,900 American women each year and kills 4,400 of them.

AP

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Oklahoman Editorial: 'Dr. Tom' Was Right

2001-08-21

PRACTICING "safe sex" might not be so safe after all.

A government report released last month said evidence of the effectiveness of latex condoms in preventing a number of sexually transmitted diseases is "currently insufficient."

Although condoms are effective in preventing pregnancy, HIV infection and gonorrhea in men, the National Institutes of Health said more study is needed on condoms and "behavior interventions" such as abstinence to determine the best ways to prevent a raft of other sexually transmitted diseases.

In the least the report appears to deal a serious blow to the safe-sex mantra delivered to the nation's teen-agers, in particular, for a number of years now by government agencies and groups like Planned Parenthood.

"For decades, the federal government has spent hundreds of millions of dollars to promote an unsubstantiated claim that promiscuity can be safe," Dr. Tom Coburn, former congressman from Muskogee, told the Washington Post.

Coburn, who asked for the study last summer while he was still serving in the House of Representatives, long has questioned the science, wisdom and morality of distributing condoms to teen-agers. It looks like he was right.

In the wake of the report some think Dr. Jeffrey Koplan, head of the Centers for Disease Control since 1998, should resign or be fired.

The calls might be justified if it can be proved the agency has known for some time that condoms might be limited in preventing sexually transmitted diseases and continued to preach their use to America's teens anyway.

October 5, 2000

The Honorable Tom Coburn
United States House of Representatives
Washington, D.C. 20515

Dear Representative Coburn:

I would like to thank you for your continued efforts to educate men and women across the country about the human papillomavirus (HPV). I, unfortunately, am one of the thousands of women who contracted this virus through, what I thought was, "safe sex."

I contracted this virus through my *first* sexual encounter three years ago, when I was 25 years old. Imagine my horror when, at my first gynecological visit, I was informed that I had a sexually transmitted disease – a disease I had never heard of. "Not me!" was my arrogant response. STDs, in my mind, were associated only with promiscuous, morally deviant individuals. This is not the case. It can happen to anyone.

I have always been a healthy, athletic, and morally principled individual. I am a college-educated woman and the daughter of a nurse and a doctor! Unfortunately, I made a poor choice – a poor, *uneducated* choice. I blame no one but myself for the consequences of my actions, but can't help but wonder if I would have made a different choice if the facts had been previously laid out before me. The physical and mental effects of this virus, and the stigma surrounding it, are devastating. I have experienced debilitating depression and low self-esteem. It has taken three years to gain back some semblance of self-respect, but the shame still lingers.

Support for an HPV education program is NOT an endorsement for sexual promiscuity; it is, rather, and endorsement for abstinence. Women AND MEN need to know that condoms do not protect against HPV. Women need to know that HPV can be linked with 90% of cases of cervical cancer. Women need to know that cervical cancer is the second-deadliest form of cancer in the world. I know this now...I wish I had known then.

This is not an easy subject to discuss, and I hope you will understand my desire for privacy. If this letter will help you persuade your colleagues that this is a real issue that affects real people, then this exercise is not in vain. I am not a constituent, but rather a citizen who appreciates what you are doing, and prays for your success. Thank you for being a voice for those of us too ashamed to speak for ourselves.

Sincerely,

An Appreciative Citizen

Thank you.

University Wire

February 27, 2001

College Nurse: "Most Cases of Herpes and HPV Are Contracted While Wearing a Condom"

Sixty-five million people are living with incurable sexually transmitted diseases (STDs) in the U.S., according to the Center for Disease Prevention and Control. This is a frightening reality that college students everywhere are facing, and many are under the illusion that a condom is giving them ultimate protection from everything.

"People think they're protected when they use a condom, but they're not," said Marlene Hjeldness, a nurse practitioner at the University of North Dakota's Student Health. "Most cases of herpes and HPV (human papillomavirus) are contracted while wearing a condom. Condoms are only good for HIV and diseases only spread by the body fluids, there is no protection against the herpes and warts that are on the skin where the condom doesn't cover."

Hjeldness said giving a student a positive test result is very hard thing to do. "Most of the girls seek a female nurse when they come in," she said. "They are in shock, tearful and crying. We give them all the pamphlets we have and tell them they can be treated here for it. I always tell them that they can come and talk to me anytime. It is unfortunate, but most girls don't want to talk to their friends about it."

Hjeldness said she feels alcohol plays a major role in the spread of STDs on college campuses. "Alcohol removes all inhibitions," she said. "Most girls will say things like 'I never would have done that if I wasn't drunk,' 'I never would have slept with him.' They are very saddened by the incident, and now they have an STD."

At UND, the most common STDs diagnosed are chlamydia, the human papillomavirus (HPV) and herpes.

Chlamydia is one of the most common STDs diagnosed around the country and at Student Health, particularly in men. This disease is difficult to detect, as it is often asymptotic. If symptoms do occur, they consist of burning urination and discharge. Chlamydia is responsible for 200,000 cases of infertility each year in the U.S., and is the leading cause of

blindness in underdeveloped countries. There are four million reported cases of chlamydia each year in the U.S. In North Dakota alone there were 934 reported cases in 1999-2000. Of these, 158 of them were in Grand Forks, and the highest number of them, 397, were reported in people ages 20-24. The second highest was 307 in youths ages 15-19.

HPV is another one of the most common STDs in the country, causing genital warts. It is estimated that as many as 24 million Americans are currently infected with the reoccurring virus. The disease most commonly causes small warts on the genitals and in women is often closely associated with the development of cervical cancer and other genital cancers. The main problem with HPV is that it too will often have no symptoms. At UND's Student Health, there were 58 cases of genital warts diagnosed on campus in the last year alone.

There were also seven cases of Herpes Simplex diagnosed at student health this past year. There are two strains of the virus: Herpes I and Herpes II. Herpes I is what occurs as cold sores found on the mouth. These reoccur less than Herpes II, which is the same sort of blistering, but on the genitals. Herpes is the fastest-growing STD in America. Some statistics say that one in every six Americans carries the virus and a total of half a million are infected each year. Early symptoms of the herpes virus consist of tingling, itching and burning in the genital area, and are followed by redness and painful blisters. One of the biggest problems with herpes is that a person may not even know that they have it, because it is often symptomless. It is said that upward of 60 percent of herpes carriers don't even know they have it. Also, according the United States Health Department, one quarter of Americans over the age of 15 are infected with the herpes virus.

There were also 81 reported cases of gonorrhea across the state, with its frequency lying in the 15-24-year-old range. "Most (men) come in because their partner told them to, or because they got a call from the state," said Mark Christenson, M.D., at Student Heath.

All positive diagnoses of chlamydia, gonorrhea, syphilis and hepatitis B are reported to the North Dakota Public Health Department. At this point the carrier of the STD is required by law to report the names of their past partners to the health department. The past partners will then be confidentially contacted by the health department and informed that they have been in contact with someone who tested positive for the disease. This is a part of the ongoing effort to control the spread of STDs in the country.

Student Health reports that it has had no positive HIV or syphilis tests in years. "As a whole we've been lucky here at UND," Christenson said.

It is important for someone diagnosed with an STD to get treatment because oftentimes the person can slip into depression or withdrawal, and avoid relationships in general. Hjeldness feels that education is key. "I think the problems start when the kids are young," she said. "We have to educate kids at a young age so they know about these things when they get to college. The education also needs to continue at the college level, because this is when the kids are becoming infected."

"I know it sounds impossible, but abstinence is the only safe way," Hjeldness said. "It's the only way we're going to start getting this problem under control."

HHS News

U.S. Department of Health and Human Services www.hhs.gov/news

FOR IMMEDIATE RELEASE
Friday, July 20, 2001

Contact: HHS Press Office
(202) 690-6343

Scientific Review Panel Confirms Condoms Are Effective Against HIV/AIDS, But Epidemiological Studies Are Insufficient for Other STDs

A special review panel led by HHS' National Institutes of Health has concluded that male latex condoms can effectively reduce transmission of HIV/AIDS. However, the panel's report also finds that epidemiological evidence is insufficient to determine the effectiveness of condoms in actual use for preventing most other sexually transmitted diseases (STDs).

The report confirms that correct and consistent use of condoms can reduce the risk of HIV/AIDS transmission. Epidemiological studies also show condoms can prevent men from acquiring gonorrhea from a female partner, the report concludes.

However, the review panel concluded that epidemiological evidence is currently insufficient to provide an accurate assessment of the effectiveness of condoms in preventing spread of chlamydial infection, syphilis, chancroid, trichomoniasis, genital herpes and genital human papillomavirus (HPV) infection.

The panel said that "because of limitations in study designs, there was insufficient evidence from the epidemiological studies on these diseases to draw definite conclusions" about the effectiveness of condoms in actual use. It noted that "the absence of definitive conclusions reflected inadequacies of the evidence available and should not be interpreted as proof of the adequacy or inadequacy of the condom to reduce the risk of STDs." The panel also recommended further well-designed research to help answer remaining questions.

At the request of former Rep. Tom Coburn of Oklahoma, the National Institutes of Health, the Centers for Disease Control and Prevention, the Food and Drug Administration, and the U.S. Agency for International Development organized the workshop held in June 2000. Twenty-eight expert panel members analyzed more than 138 peer-reviewed, published studies on the properties and user patterns of the male latex condom during penile-vaginal intercourse.

Meta-analysis of several studies showed an 85 percent decrease in risk of HIV transmission among consistent condom users versus non-users. These data provide compelling evidence that consistent use of the latex male condom is a highly effective method for preventing HIV transmission, the report said. Studies also show a 49 percent to100 percent reduction in risk of gonorrhea among men reporting condom use compared with non-users.

For the other STDs reviewed, existing studies were found insufficient to accurately assess effectiveness. For HPV, the panel found there was no evidence that condom use reduced the risk of HPV infection, but study results did suggest that condom use might afford some reduction in risk of HPV-associated diseases.

STDs, including HIV infection, affect more than 65 million people in the United States. Many STDs can cause infertility, problems with pregnancy, and can be passed from a mother to her infant. Long-term infection with HPV can cause cervical cancer if not diagnosed (through annual pap smears) and treated. In addition, most STDs increase the likelihood of transmitting HIV infection at least 2 to 5-fold. While most STDs can be treated successfully, no vaccine is currently available to prevent infection by organisms that cause STDs, except for hepatitis B.

The workshop summary, "Scientific Evidence on Condom Effectiveness for Sexually Transmitted Disease (STD) Prevention," is available on the Web at *http://www.niaid.nih.gov/dmid/stds/condomreport.pdf*

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Joint Statement

Congressman (Ret.) Tom Coburn, M.D.
Congressman Dave Weldon, M.D.
Physicians Consortium
Catholic Medical Association

It is time for the Centers for Disease Control and Prevention (CDC) to start telling the whole truth about condoms!

The above named groups, representing more than 10,000 physicians and medical professionals, are gathered in Washington, D.C., today, July 24, 2001, to testify to a health crisis that has devastated our nation for the last 20 years.

The epidemic of sexually transmitted diseases (STDs) has affected millions of people in America and around the world. As practicing physicians, we see the pain and suffering the STD epidemic has inflicted upon individuals and families, and we have been attempting for many years to persuade the public health community that the policy of STD prevention by condom use cannot succeed.

We believe the failure of public health efforts to prevent the STD epidemic in America is related to the CDC's "safe-sex" promotion and its attempt to withhold from the American people the truth of condom ineffectiveness.

The organizations and individuals concurring with this statement have extensive evidence that the CDC has systematically hidden and misrepresented vital medical information regarding the ineffectiveness of condoms to prevent the transmission of STDs. The CDC's refusal to acknowledge clinical research has contributed to the massive STD epidemic.

We believe that the CDC may be in direct and intentional violation of a federal law (P.L. 106-554) passed last year that requires the CDC (and other federal agencies) to communicate medically accurate information to the public and to enforce the use of medically accurate information by contractors, grantees and sub-grantees.

On Friday, July 20, the U.S. Department of Health and Human Services released an official government document detailing the research on condom effectiveness. This document supports our contention that condoms offer extremely limited benefit to our patients.

Specifically, the government document, based on all available peer-reviewed clinical research, details the following facts about condom effectiveness:

STD	Incidence	Prevalence	Condom Effectiveness
HIV	40,000	900,000	Relative risk = .15
Gonorrhea	650,000	NA	Women – No clinical proof of effectiveness Men – Some effectiveness
Chlamydia	3 million	2 million	No clinical proof of effectiveness
Trichomoniasis	5 million	NA	No clinical proof of effectiveness
Syphilis	70,000	NA	No clinical proof of effectiveness
Genital Herpes	500,000	45 million	No clinical proof of effectiveness
Human Papillomavirus (HPV)	5.5 million	20 million	No clinical proof of effectiveness

Other reputable medical organizations are also on record as saying that condoms do not protect against all STDs, especially against HPV. In fact, Dr. Richard D. Klausner, Director of the National Cancer Institute, concluded that, "additional research efforts by NCI on the effectiveness of condoms in preventing HPV transmission are not warranted."

The CDC has had full knowledge of this medical literature for many years and has chosen not to release this information to the American public.

We believe that the CDC made numerous attempts to delay, and even alter, the NIH document on condom effectiveness. Specifically, the CDC demanded the inclusion of an unproven and theoretical model into the document, which originally was to have included only empirical, peer-reviewed data. The addition of this hypothetical model not only weakens the scientific basis of the NIH document as originally conceived, but adds unwarranted confusion and misinformation to what otherwise is a clear-cut repudiation of condom effectiveness. By its insistence to include the hypothetical model, the CDC further demonstrates its apparent attempt to withhold information that women need to protect themselves from STDs.

While the CDC's model is purely hypothetical, our patients are not. They are real people with real medical conditions who need real information, real compassion and real treatment. There is nothing theoretical about the cases of STDs we see in our offices. The data in the NIH document, based on real people living real lives, show little or no evidence of condom protectiveness against real STDs.

Our greatest concern is for the millions of our patients and their families who have suffered from this policy of cover-up and deception. The CDC has promoted condom-use programs that have been used to educate an entire generation. Because they believed condoms would protect them during intercourse, millions of women in our country now suffer from the ravages of diseases, including pelvic infections, infertility and cervical cancer.

We physicians, who have depended upon the CDC to develop sound public health policy to protect the health and well being of our patients, are appalled at public health officials who are withholding the very information we need to educate and care for our patients.

It falls upon practicing physicians, not the CDC, to help pick up the pieces in the lives of millions of young women who contract painful, even deadly, STDs. Everyday we see the

hopes and dreams, as well as the physical and emotional health, of our patients robbed by STDs. We demand more from the CDC, because we demand better for our patients.

There is a health model that completely protects against all STDs; it is abstinence until marriage with an uninfected partner and monogamy thereafter. If we, as a medical community, are really serious about the STD epidemic, this is the message we must begin sending to our young people. But, we need the CDC's help to do so.

We plead with the CDC to stop using theoretical models that have no basis in actual clinical research, to start telling the truth and to stop breaking the law. Our patients deserve no less.

A call to action:

- We call upon President Bush to request the immediate resignation of Dr. Jeffrey P. Koplan as the Director of the CDC. Only with fresh and bold leadership at the CDC, dedicated to primary prevention as opposed to social ideology, can we, as a country, start moving toward genuine sexual health.
- We call for the Food and Drug Administration (FDA) to require condom labeling that complies with the law and reflects the clinical science on condom effectiveness.
- We call for the CDC and other federal health agencies and all government partners, contractors, grantees and sub-grantees to comply with the law mandating the use of medically accurate information based on clinical studies.
- We call on the U.S. Department of Health and Human Services to strip federal funding from all government agencies, contractors, grantees and sub-grantees whose educational and promotional materials, including web sites, do not comply with the law mandating the use of medically accurate information based on clinical studies.
- We call for a congressional hearing on the scandal of the CDC's cover-up of information vital to women's health.

July 24, 2001

Congressman (Ret.) Tom Coburn, M.D.
Congressman Dave Weldon, M.D.
Physicians Consortium
Catholic Medical Association

Summary of NIH Report On Condom Effectiveness

STD	Incidence	Prevalence	Condom Effectiveness
HIV	40,000	900,000	85% Risk Reduction
Gonorrhea	650,000	NA	*Women:* No Clinical Proof of Effectiveness *Men:* Some Risk Reduction
Chlamydia	3 million	2 million	No Clinical Proof of Effectiveness
Trichomoniasis	5 million	NA	No Clinical Proof of Effectiveness
Chancroid	1,000	NA	No Clinical Proof of Effectiveness
Syphilis	70,000	NA	No Clinical Proof of Effectiveness
Genital Herpes	1 Million	45 million	No Clinical Proof of Effectiveness
Human Papillomavirus (HPV)	5.5 million	20 million	No Clinical Proof of Effectiveness

* Source: Cates, 1999

The Declines in Adolescent Pregnancy, Birth and Abortion Rates in the 1990s: What Factors Are Responsible?

A special report commissioned by

The Consortium of State Physicians Resource Councils

January 7, 1999

The Declines in Adolescent Pregnancy, Birth and Abortion Rates in the 1990s: What Factors Are Responsible?

By Jeffrey M. Jones, M.D., Ph.D., William Toffler, M.D., Reed Bell, M.D., Joanna K. Mohn, M.D., Gaylen Kelton, M.D., Robert Weeldreyer, M.D., Hal Wallis, M.D., G. Steven Suits, M.D., John R. Diggs, Jr., M.D., Harold Cox, M.D. and Kent Jones, M.D.

Background: *During the 1990s the rates of pregnancy, birth and abortion among adolescents in the United States have declined. Taken in composite, these declines are the first in several decades. The question remains: What factor or factors are most responsible for the declines?*
Approach: *The data on adolescent pregnancy and birth rates, abortion, contraceptive use, and sexual behavior and attitudes were analyzed in order to ascertain correlation and possible cause-and-effect relationships.*
Findings: *The specific factors and the exact interrelationship of the factors responsible for the decline in teen pregnancy, birth and abortion rates cannot be precisely determined. However, the contention that these declines are due to increased contraceptive use by teenagers does not withstand critical analysis and review. Out-of-wedlock birthrates to sexually experienced female teens rose 29% from 1988 to 1995, despite a 33% increase in the use of condoms at last intercourse.*

Decreased rates of pregnancy, abortion and births among the entire adolescent cohort seem to correlate with a corresponding decrease in teenage sexual activity. Because of the difficulty in precisely determining the cause of these positive trends, the issue as to why adolescents have become increasingly involved in abstinent behavior should be the subject of further study.
Summary: *Abstinence and decreased sexual activity among sexually active adolescents are primarily responsible for the decline during the 1990s in adolescent pregnancy, birth and abortion rates. Attributing these declines to increased contraception is not supported by the data. Intervention programs focused on abstinence may have significantly contributed to the decline in sexual activity, but further research is needed to test this hypothesis.*

Background

Beginning in the 1960s and 1970s, various statistical measures confirmed a dramatic increase in sexual activity by adolescents as reflected by the consequences.

- The birthrate among unmarried females aged 15 to 19 years increased 90% from 22.4 per 1,000 in 1970 to 42.5 per 1,000 in 1990.[1]
- The abortion rate among females aged 10 to 19 years rose 94% from 9.7 per 1,000 in 1972 to 18.8 in 1990.[2]

With few period-to-period exceptions through the late 1980s, these consequential statistics reflected a steady increase in teens having sex. However, in recent years the trend in the measures of these consequences has begun to moderate and even reverse.

The birthrate declined 4.2 percent for unmarried female teens and 11.9 percent for all female teens from 1991 to 1996 (Table A).

Table A	1991	1996	% change
Birthrate per 1,000 females aged 15 to 19			
Total[3]	62.1	54.7	-11.9%
Unmarried[4]	44.8	42.9	-4.2%

Abortions were not responsible for the drop in the birthrate. In fact, rate of abortions for teens dropped during a similar period (Table B).

Table B	1990	1995	% change
Abortion rate per 1,000 females aged 10 to 19 years[5]	18.8	13.5	-28.2%

Correspondingly, the rate at which teenagers became pregnant fell 9.1 percent between 1992 and 1995 (Table C).

Table C	1992	1995	% change
Teenage pregnancy rate per 1,000 females[6]	99.7	90.6	-9.1%

An Increase in Contraception?

Immediately after the data above were released in May and June of this year, advocates of safer-sex programs pointed to increased condom use by teens as a principle reason for the declines in pregnancy and birth rates. Consider the following:

"Contributing to this decline in [birthrates] are indications that...sexually active teenagers are more likely to use contraception." Centers for Disease Control
"Those [teens] who do have sex are using contraceptives more reliably." Washington Post
"Their [female teens] likelihood of pregnancy has decreased. Increases in contraceptive use by adolescent females contribute to this change." HHS
"Increased contraceptive use – especially condoms – was a major factor in the decline of unintended pregnancies." NARHP

And their claims were not without some statistical support. After all, condom use at last intercourse increased significantly by both teenage males (+21%) and females (+33%) from the late 1980s through the mid 1990s (see Table D). Condom use increased even more among specific high-risk teenage demographic groups, such as black females, a cohort that also experienced a significant increase in the use of Norplant and Depo-Provera.

The decline in pregnancy and birth rates and increase in condom use led to the premature conclusions that total contraception rates increased and were responsible for the declining birthrates. But, in matters of statistical and behavioral research, formulating conclusions during the initial review of data is a careless practice.

Contraception-Use Rates Have Not Increased

A more complete review of sexual practices by teenagers from 1988 to 1995 is not compatible with the view that contraception-use rates increased. Total contraception-use rates not only did not increase – the data indicate that they may have actually declined slightly (Table D).

Table D Contraceptive use during last intercourse by sexually active teens	1988			1995			Change in combined contraceptive use, '88 to '95
	Condoms	Oral	Combined	Condoms	Oral	Combined	
Males, 15-19 (and partner)[7]	53%	37%	90%	64%	28%	92%	+2.2%
Females, 15-19 (and partner)[8]	27%	42%	69%	36%	23%	59%	-14.5%

In order to compare 1995 with 1988, the data for oral and condom contraceptive use was added in Table D to yield combined contraceptive use at last intercourse. This calculation includes only oral and condom contraceptives for two reasons. First, these two methods represent the dominant contraception of choice by teens in both comparison years. Second, data for injectable and implantable contraception is not available for 1988.

The combined data show that while condom use did increase, the rise was more than offset by a decrease in the use of oral contraceptives. From 1988 to 1995, sexually active adolescent females increased their use of condoms at last intercourse by 33 percent (36% vs. 27%), but decreased their use of oral contraceptives by 45 percent (23% vs. 42%).

Thus, these females were 14.5 percent less likely to use condoms or oral contraception in 1995 compared to 1988. This fact led Joyce Abma from the National Center for Health Statistics and Freya L. Sonenstein from the Urban Institute to make the following statement:

> *"Between 1988 and 1995 there has been little change in the proportion of currently sexually active teens reporting that they used no method of contraception at the last intercourse."*[9]

This combined calculation ignores two factors that could influence the data on the proportion of female teens protected against pregnancy.

The first factor is that the combined calculation assumes no dual use. But, dual use at last intercourse among never-married young people aged 14 to 19 is relatively small at 5.8 percent of females and 4.1 percent of males.[10] Further, the combined calculation was performed in the same manner for both 1988 and 1995. Therefore, combined data without an adjustment for dual use is valid as a relative comparison of contraceptive use in 1995 to 1988.

The second factor is that injectables/implantables are not included in the combined calculations. However, even if the use of injectable/implantable contraception was included for this cohort on Table D (7% usage rate at last intercourse in 1995),[11] total contraception use still fell.

The decline in the use of contraception by female teens has been confirmed in other research literature. In the January/February 1998 issue of *Family Planning Perspectives* ("Trends in Contraceptive Use In the United States: 1982-1995," Table 1), authors Piccinino and Mosher included data that indicate a slight drop from 1988 to 1995 in the proportion of sexually experienced U.S. females aged 15-19 reporting use of any method of contraception. The data on Table E show that the use of any method of contraception (including injectables and implantables) by sexually experienced female teens dropped from 61.0 to 60.1 percent.

Table E	1988	1995
A. Percent of all females aged 15 to 19 currently using any contraceptive method[12]	32.1%	29.8%
B. Percent of females aged 15 to 19 who are sexually experienced[13]	52.6%	49.6%
C. Proportion of sexually experienced females aged 15 to 19 who are using any method (C=A/B)	61.0%	60.1%

Safer-sex advocates may claim that even without a net increase in contraceptive use teens are better protected against the risk of pregnancy because of the effectiveness of injectables/implantables. But it is important to note that the sizable shift from oral contraception to condoms represents a shift to less efficacious protection against pregnancy.

It is possible to statistically calculate the change in protection from pregnancy among female teens by the switch from oral contraception to condoms and injectables/implantables. To make this calculation it is necessary to factor the percentage of teens using different methods of contraception by the accepted levels of effectiveness for each method.

Table F provides a risk-adjusted contraceptive protection index. For example, in 1988, 69 percent of sexually active females aged 15 to 19 used condoms and/or oral contraception at last intercourse. But adjusted for method effectiveness, the percentage index dropped to 65 percent. Using the same formula for 1995, the percent of the cohort using contraception (including I/I) dropped from 66 percent to 61 percent after the adjustment for effectiveness.

Table F Sexually Active Females 15-19	1988				1995			
	Condom	Oral	I/I	Total	Condom	Oral	I/I	Total
A. % usage at last intercourse	27%	42%	N/A	69%	35%	23%	7%	66%
B. Method effective ness[14]	85%	99%			85%	99%	99 %	
C. Hypothetic al Protection Index (C=AxB)	23%	42%		65%	31%	23%	7%	61%

Thus, the use of injectable/implantable contraception in 1995 did not offset the reduced protection represented by the switch from birth control pills to condoms. This is yet another reason why contraception would not account for reduced pregnancy and birth rates.

In summary, based on lower reported contraceptive use and a switch to a less effective prevention method (condoms vs. oral), sexually active adolescent females in 1995 were less protected against pregnancy than in 1988. The claim that the drops in pregnancy, birth and abortion rates are due to increased contraceptive use is inconsistent with the data.

Non-Marital Birthrates Among Sexually Experienced and Active Teens Have Risen Sharply

The out-of-wedlock birthrates to sexually experienced female teens (have ever had sex) and sexually active teens (sex in past 3 months) have increased sharply during the 1990s.

To calculate the birthrate among adolescents, the government uses the total number of births by female teens as the numerator and the total number of female teens as the denominator. This formula is misleading because it does not recognize that abstinent female teens do not become pregnant.

The convention of reporting on birthrates within the entire cohort of 15 to 19 year-old females has masked the steady increase in the out-of-wedlock birthrate among sexually experienced and sexually active teens.

A more revealing way to consider the data is to calculate the out-of-wedlock birthrate among sexually experienced and sexually active female teens. This calculation would allow researchers to more accurately determine the impact of national interventions aimed at reducing non-marital births.

Table G shows the out-of-wedlock birthrate to sexually experienced females aged 15 to 19. The birthrates per 1,000 unmarried females, aged 15 to 19, are from the National Center for Health Statistics. The percent of females 15 to 19 who have had premarital sex is from the National Survey of Family Growth. See footnote (a) for a more complete discussion on calculating birthrates to sub-groups of teens.

This calculation shows that the long-term trend of out-of-wedlock birthrates to sexually experienced female teens has increased substantially during the 1990s. Based on this data, the out-of-wedlock birthrate to sexually experienced females aged 15 to 19 increased 41.8 percent from 1976 to 1995 and 29.3 percent from 1988 to 1995.

Table G Year	Birthrate per 1,000 unmarried females aged 15 to 19[15]	% of females 15 to 19 who have had premarital sex (sexually experienced)[16]	Non-marital birthrate per 1,000 sexually experienced females 15 to 19
1976	24.6	39.0%	63.1
1982	28.7	45.2%	63.5
1988	36.4	52.6%	69.2
1995	44.4	49.6%	89.5
Percent change '76 to '95 '88 to '95			 +41.8% +29.3%

a) The calculation of non-marital birthrates to sexually experienced female teens was performed by using the total out-of-wedlock birthrate to females aged 15 to 19 as the numerator and the proportion of female teens who reported premarital sex as the denominator. For example, the non-marital birthrate of 89.5 per 1,000 sexually experienced female teens in 1995 was calculated by dividing 496 (number of female teens per 1,000 who reported premarital sex) into 44.4 (births per 1,000 unmarried females aged 15 to 19).

The birthrates to sexually active female teens were calculated in the same manner.

For a more complete discussion on calculating birthrates by adolescent sub-groups, see the discussion in the article "The Decline in US Teen Pregnancy Rates, 1990-1995," *Pediatrics*, Vol. 102, No. 5, November 1998.

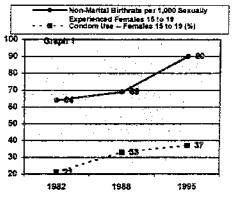
The *Pediatrics* article concluded that the pregnancy, abortion and birthrates among sexually experienced and sexually active teens have held steady or declined significantly since the 1980s. However, authors Kaufmann, et al. used data for all teen births. The calculation of out-of-wedlock birthrates among sexually experienced and sexually active teens, as shown herein, leads to a dramatically different conclusion.

Table H shows the same analysis for sexually active females, aged 15 to 19.

Table H Year	Birthrate per 1,000 unmarried females aged 15 to 19[17] (Entire teen female cohort)	% of females 15 to 19 who are sexually active (sex in past 3 months)[18]	Non-marital Birthrate per 1,000 sexually active females 15 to 19
1988	36.4 (53.0)	42.7%	85.2
1995	44.4 (56.8)	39.7%	111.8
Percent change '88 to '95			+31.2%

Based on this data, the out-of-wedlock birthrate to sexually active females aged 15 to 19 increased 31.2% from 1988 to 1995.

The increases shown in Tables G and H occurred despite sharply higher condom usage, as illustrated in Graph 1.



From 1982 to 1995, the out-of-wedlock birthrate per 1,000 sexually experienced females aged 15 to 19 increased 40.9 percent, from 63.5 to 89.5 (Table G).

During the same time span the proportion of teenage females who reported using contraceptives increased their use of condoms 76 percent (from 21% to 37%).[19] The implications of the data in Table G and H and Graph 1 should not be minimized – out-of-wedlock birthrates have increased among sexually experienced and sexually active female teens despite an increased use of condoms.

It should be noted that the proportion of female teens who reported premarital sex was used as a proxy for unmarried female teens in Table G. It is possible that some females who reported having had premarital sex were married at the time of reporting.

However, the authors believe that the use of specific data limited to never-married female teens would not significantly alter the results shown. This is because (1) the proportion of married teens in this age category is low (4.5% in 1995 NSFG), and, (2) the proportion of never-married female teens who have ever had sex is not much different than the proportion of all teens who have ever had sex.

For example, in 1995, 48.1 percent of never-married female teens reported having had sex compared to 50.4 percent of all teens. So while the exact calculations of out-of-wedlock birthrates to sexually experienced and sexually active female teens might change if a pure data set limited to

never married teens was used, the pattern of the results would remain the same. The authors encourage other researchers to further expand the study of out-of-wedlock birthrates.

Declining Sexual Activity Rates

Obviously, programs in safer-sex education and condom distribution have not reduced out-of-wedlock birthrates among sexually experienced teens. On the other hand, there has been a decrease in the overall teen birthrate. The following data suggest reasons why. Tables I and J confirm that more teens are choosing abstinence.

Table I % teens 15-19 who have ever had sex[20]	1988	1995	% change '95 vs. '88
Never-married Males – NSAM	60.4%	55.0%	-8.9%
Females – NSFG	52.6%	49.6%	-5.7%

Table J % high school teens 15-19 who have ever had sex[21]	1990	1997	% change '97 vs. '90
Males – YRBS	60.8%	48.9%	-19.6%
Females - YRBS	48.0%	47.7%	-.6%

Sexually experienced teen males have become less sexually active and have fewer partners (Table K).

Table K % H.S. teens[22]	1990	1995	1997	% change '97 vs. '90
Had intercourse in past 3 months	39.4%	37.9%	34.8%	-11.7%
Males	42.5%	35.5%	33.4%	-21.4%
Females	36.4%	40.4%	36.5%	+.3%
Had four or more partners	19.0%	17.8%	16.0%	-15.8%
Males	26.7%	20.9%	17.6%	-34.1%
Females	11.6%	14.4%	14.1%	+19.5%

A very strong trend is reflected in Tables I, J and K. The positive correlation between the reductions in teen sexual activity and teen pregnancy rates may be mostly due to more abstinent behavior by male, rather than female, adolescents. From 1990 to 1997 there was a 19.6 percent decline in the proportion of adolescent males who have ever had sex compared to a .6 percent decline among adolescent females (Table J). From 1990 to 1997 there was a 21.4 percent drop in the proportion of adolescent males who have had sex in the past three months compared to a .3 percent increase among adolescent females (Table K). And, from 1990 to 1997 there was a 34.1 percent decline in the proportion of adolescent males who have had four or more partners compared to a 19.5 percent increase among adolescent females (Table K). So while the percent of all female teens who have ever had sex has declined, those females remaining sexually active have become increasingly promiscuous. A discussion of this phenomenon is not within the scope of this paper, but should be the subject of further study.

Promotion of Abstinence

Tables I, J and K show that there has been a significant overall decline in teen sexual activity from 1988 to 1995 and beyond, simultaneous with an overall decline in teen pregnancy, birth and abortion rates (Tables A, B and C). Increased condom use has been invoked to explain the latter, yet increased condom use is outweighed by a shift away from using more efficacious oral contraceptives. Tables G and H show that the non-marital birthrate to sexually experienced and sexually active female teens actually increased sharply from 1988 to 1995.

Thus we find it more reasonable to suggest reduced sexual activity as the hypothesis capable of explaining reduced pregnancy, birth and abortion rates. In fact, the decline in the overall birthrates among adolescent females during the 1990s is due primarily to teens that have never had sex or are not currently having sex.

Abstinence-only programs may be playing an increasing role in bringing about reduced teen sexual activity. In the remainder of this publication, therefore, we present: 1.) Observations on the history and nature of abstinence programs; 2.) Societal factors that support the choice of abstinence; and 3.) Promising preliminary results of abstinence-only programs.

1. History and Nature of Abstinence Programs

Abstinence component of comprehensive sexuality programs. In the early 1990s comprehensive sexuality programs began emphasizing abstinence as the preferred choice for teenagers. Such programs are called "abstinence-based." While abstinence-only advocates accuse abstinence-based education of sending a confusing dual message, it is likely that the abstinence component has influenced some adolescents. All of this raises a very interesting question: If comprehensive sexuality education has contributed to the decline in teen pregnancy, might it be due primarily to the abstinence component? This is a very real possibility since, as shown earlier in this research study, contraceptive use is not associated with reduced unintended out-of-wedlock births.

Abstinence-only programs. There has been an explosive growth in privately funded abstinence-only programs during the 1990s. An indication of that growth is shown in Table L.[23]

Table L Abstinence-only category	# of students reached - 1986	# of students reached - 1989	# of students reached - 1997
Pledge card based	0	0	750,000
Crisis pregnancy centers	12,164	69,918	620,250
Private curriculum/speakers	234,950	572,656	1,676,032
Total	247,114	642,574	3,046,282

As a result, there has been a 12-fold increase in the number of teens reached by privately funded abstinence programs in the span of a decade.

Opponents of abstinence-only programs point out that the effectiveness of such programs has not been documented. This may be based more on philosophical opposition to the abstinence-only message than on an objective consideration of all the facts. Accordingly, four observations are worthy of note.

First, very little research has been conducted on abstinence-only programs. Douglas Kirby in his booklet "No Easy Answers" stated that "*more research should be done on*

these programs...very few such programs have been well evaluated, and, thus, there is little evidence to determine whether or not abstinence-only programs can delay intercourse." In other words, the jury is still out.

Second, the abstinence-only programs that have been evaluated in peer-reviewed research journals have been very narrowly defined in scope and low in intensity. An example is an abstinence program in Philadelphia recently declared as ineffective in *JAMA*.[24] The entire abstinence message therein studied was delivered during just two Saturday sessions. Researchers have concluded that any intervention program, in order to be effective, must be multi-faceted and of adequate intensity and duration.[25]

Third, some of the abstinence programs that have been evaluated do not meet the standards set by abstinence-only education experts. An example is Education Now and Babies Later (ENABL), the well publicized program in California. ENABL was a limited scope program. But more importantly, ENABL was never fully endorsed by abstinence-only education experts. From the onset, abstinence-education advocates did not acknowledge ENABL as a true abstinence program because of its limited duration, use of values-clarification methods and reliance on teachers who were not trained in or did not philosophically agree with an abstinence-only message.

Philosophical buy-in by teachers to a message correlates highly with the impact of the message upon students. In a 1994 study researchers reported *"that teachers are a vital and important ingredient in the successful implementation of these programs [meaning] that an abstinence sex education program may succeed or fail not simply because of the merit of the program but because of the lack of either teacher commitment to implementation or support for the program objectives or both."*[26]

Finally, abstinence-only advocates also claim that a much higher standard of research protocol is applied to abstinence-only programs than to comprehensive sexuality programs. One example of this apparent double standard is the research on condom availability in Los Angeles area high schools. In that study there was a 41 percent pre-to-post test participant-dropout rate due to parental opposition.[27]

Another example of the double standard is the Center for Disease Control's "Programs That Work" initiative. "Programs That Work" features five interventions that CDC claims are quite effective. Not one of the five has data measuring a reduction in teen pregnancy or STD rates. Yet, these programs were developed to reduce pregnancy and STD rates.

2. Societal Factors That Encourage Abstinence

A number of societal factors also encourage abstinence.

HIV/AIDS Education. Perhaps not since the polio crisis of the 1950s has the national consciousness on a medical issue been so raised as it has been for HIV/AIDS. Almost all teens now receive instruction on HIV/AIDS: 92 percent of males and 94 percent of females.[28] The HIV/AIDS scare has likely impacted the sexual behaviors of many adolescents in favor of abstinence.

Instruction on Refusal Skills. As equally common among females as HIV/AIDS information is instruction on how to say "no" to sex. In fact, 93 percent of adolescent females received instruction on refusal skills in 1995. Three quarters of adolescent males received similar instruction.[29]

Generational Changes in Attitudes. There are several theories of generational sociology. One view holds that generational history is seamless -- each new generation simply builds upon the foundation established by its predecessors. Another view holds that generational history is cyclical -- attitudes abandoned by one generation often reappear after a skip of two or more generations. If the latter theory is true, then the recent declines in teen sexual activity may, in some part, be due to generational factors. Teenagers today could be rejecting the view of sexual behavior held by their baby-boomer parents (who are widely credited with the sexual revolution of the 1960s and 70s) in favor of the traditional view held by today's more senior citizens. If this observation is valid, then an unambiguous abstinence message should be quite well received by the next few generations.

A recent article in *Family Planning Perspectives* confirms the link between more conservative attitudes among teens and declining sexual activity rates.[30] In the article, "Understanding Changes in Sexual Activity Among Young Metropolitan Men: 1979-1995," authors Ku, et al. state *"More permissive attitudes about premarital sex were strongly associated with high rates of intercourse. Adolescent males who completely disapproved of premarital sex were far less likely to have had sex recently than were those who approved of it."* The study also demonstrates that *"religiosity is part of reason for the shift in attitudes."*

The article suggests that these attitudinal *"changes reflect a growing trend and not merely a unique fluctuation in the sexual beliefs of American youth."*

General Societal Attitudes. There have been a number of studies in recent years showing that society in general has embraced an abstinence-until marriage viewpoint.

A survey of nearly 4,980 people by Wirthlin Worldwide found that 71 percent of the national respondents believe couples should wait to have sex until marriage.[31] A *New York Times* poll found that nearly half of teens polled said sex before marriage is always wrong.[32] In an Emory University survey of 1,000 sexually active teen girls, 84 percent said they would like to learn how to say no to sex.[33] In a 1994 Roper-Starch study, 54 percent of students who have already tried sex indicated they should have waited.[34] In a study commissioned by the National Campaign to Prevent Teen Pregnancy, 95 percent of both adults and teens stated that it is important for high school students to be given a strong abstinence message from society.[35]

3. Promising Results of Abstinence-Only Programs

There is increasing evidence that an unambiguous abstinence message shows promise in changing the behavior of teens.

Add Health Study. The September 10, 1997 issue of *JAMA*[35] published an article on the first wave of findings from the National Longitudinal Study on Adolescent Health (Add Health) -- the most extensive study on adolescent risk behavior ever conducted. The study showed that the factor

most strongly associated with a delay in the onset of sexual activity was a pledge of abstinence. In fact, the pledge of abstinence was three times more strongly associated with a delay in sex than the next most positively correlated factor. A pledge of abstinence is the cornerstone of a program popular among many church youth groups called True Love Waits. Nearly 16 percent of all female teens and 10 percent of all male teens have signed pledge cards and joined peer support groups through True Love Waits and similar programs.[37]

Simply signing a pledge of abstinence -- in and of itself -- is probably not the sole reason signers significantly delay sexual activity. There are likely a number of familial, religious and personal risk-protective factors that lead an adolescent to sign the pledge. Nevertheless, the signing itself does represent a point of decision and commitment, which the Add Health data show is highly significant as a singular risk-protective factor. Further research is needed to more thoroughly understand the dynamics of the abstinence pledge.

Other factors reported by Add Health as significantly associated with a delay in the age of sexual debut are parental disapproval of adolescent contraception and parental disapproval of adolescent sex.

STARS. "Students Aren't Ready for Sex" began in 1994 as a pilot project in Multnomah County, Oregon in four middle schools that served about 1,000 students. In 1998/99 STARS will reach all but five of Oregon's 36 counties and serve more than 33,000 students through its peer-mentoring abstinence program. In December 1997 the Oregon STARS Foundation contracted with the Oregon Health Policy Institute to evaluate STARS. The evaluation concluded in July 1998. Among the results:[38]

- 70 percent of students said STARS helped them decide to abstain from sex.
- 77 percent of students said the program helped them understand their personal rights to set limits.
- Rates of sexual involvement among participating middle school students surveyed dropped from 9.7 percent before to 5.3 percent after STARS.[39]

The Michigan Abstinence Partnership. In the early 1990s the State of Michigan began a major campaign called "The Michigan Abstinence Partnership." The partnership has provided communities with technical assistance, education materials and promotional items. Each participating community has developed a coalition which develops and implements unique abstinence activities, such as youth rallies, educational sessions for parents, abstinence curricula, family activity days, recreational events and peer education sessions.

Importantly, the partnership has had a goal of making teen abstinence the culturally accepted norm. The result has been a decline in teen birthrates far exceeding the national average. From 1991 to 1996 the teen birthrate in Michigan declined 19.1 percent from 58.7 to 47.5 births per 1,000 females aged 15 to 19.[40] This compares to a national decline of only 11.9 percent during the same period (see Table A).

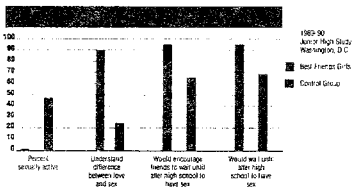
Tennessee Study. Of the 10 largest counties in Tennessee with statistics on pregnancy broken-down among black and white adolescents, research indicates that teen pregnancies in the three that taught abstinence-only in schools declined between 14 and 38 percent from 1991 to 1996. By comparison, the four that taught safer-sex education or had no system-wide sex education experienced a maximum decline of only 7 percent.[41]

Table M. Teen Pregnancy Rates in Counties with Populations over 50,000 and Black and White Statistics, 1991 to 1996

County	Sex Ed	1991 (per 1,000)	1996 (per 1,000)	% Change
Madison	Abstinence	79.9	49.3	-38.3%
Hamilton	Abstinence	69.6	52.1	-25.1%
Shelby	Abstinence	92.1	79.1	-14.1%
Davidson	Community initiatives	74.3	64	-13.9%
Knox	Mixed message	46.2	40.5	-12.3%
Sumner	Teachers guide	49.2	44.5	-9.6%
Williamson	Safer-sex education	23.9	22.2	-7.1%
Montgomery	Safer-sex education	47.8	45.3	-5.2%
Rutherford	No systematic sex ed	41.0	39.9	-2.7%
Wilson	No systematic sex ed	36.3	36.5	+0.5%

Best Friends.[42] The Best Friends mentoring and abstinence education program in Washington, D.C. has been highly effective. Only 10 percent of Best Friends girls reported having sexual intercourse compared to 37 percent of D.C. middle school girls. Best Friends girls also were found to have a one-percent pregnancy rate, compared to a 26-percent rate among all high school-aged D.C. girls. Graph 2 reports on other aspects of the effectiveness of Best Friends.[43]

Graph 2



Denmark, SC Community Program. Between 1982 and 1987, a program was implemented in Denmark, SC. The community-based program had multiple components -- classroom abstinence education, adult education, motivational speakers, newspaper articles, intensive teacher training, and faith community and civic leadership involvement. Prior to the implementation of the program, the area had an adolescent pregnancy rate of 61 out of every 1,000 adolescent girls aged 14 to 17. In the second and third years of the program, the adolescent pregnancy rate dropped to 25 out of every 1,000 girls, while comparison schools not

participating in the program remained at more than twice that rate.[44]

Several years after the completion of the Denmark program, some researchers claimed that the study was flawed because a school nurse had been distributing condoms. In 1998 the U.S. Department of Health and Human Services, which funded the program, reiterated that the community intervention was designed from the onset and funded as abstinence-only and that an official HHS investigation was unable to attribute the decline in the pregnancy rate to the activities of the school nurse. The controversy raises an interesting question: Should the results of a contraceptive-based intervention be invalidated if it is later determined that an abstinence-only message existed within the intervention community?

Conclusion

The evidence points to sexual abstinence, not increased contraceptive use, as the primary reason for the decline in teen pregnancy and birth rates throughout the 1990s. It appears possible that programs aimed at producing abstinent behavior have been more successful than programs aimed at increasing safer-sex practices in reducing unintended births to adolescents. Douglas Kirby, a noted sex education researcher, was prophetic in 1991 when he noted that *"it may actually be easier to delay the onset of intercourse than to increase contraceptive practice."*[45]

The increase in teen abstinence is likely due to a combination of factors -- the HIV/AIDS epidemic, the growth of abstinence-only programs, generational changes and increased cultural acceptance of abstinence.

The authors believe that the correlation between increased condom usage and higher out-of-wedlock birthrates among teens has significant public health policy implications. In 1997/98 a new federal program was implemented to promote an abstinence-only message. The timing of the federal Title V abstinence program seems well placed. Educational and youth programs should increase their emphasis on the abstinence-until-marriage message. Further research should be conducted into what components within an abstinence program contribute most to overall effectiveness.

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Thursday, March 25, 1999

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Teen pregnancy drop credited to awareness of abstinence benefits

By Ed Vogel
Donrey Capital Bureau

CARSON CITY -- State teen-age leaders attributed the decline in the teen-age pregnancy rate Wednesday to an increased awareness in the advantages of abstinence.

"People know there is a risk with sex," said Jessica Winters, chairwoman of the Governor's Youth Advisory Council. "There could be lifelong maintenance for a moment of pleasure."

Winters, 19, of Las Vegas and other members of the advisory council held a news conference to announce that the teen-age pregnancy rate fell 22 percent in Nevada between 1993 and 1998.

Still, 49 of every 1,000 girls ages 15 to 17 became pregnant last year in Nevada.

The rate is the highest in the nation, according to Yvonne Sylva, administrator of the state Health Division.

But Sylva said the drop below 50 pregnancies per 1,000 lets the state achieve one goal early; her agency had hoped to go below that figure by 2000.

"Even one teen pregnant girl is one too many," Sylva said.

In 1998, 107 babies were born to Nevada girls 10 to 14, 1,747 to ages 15 to 17, and 2,960 to ages 18 to 19.

In the last three years a number of state programs have been launched to reduce the pregnancy rate, including the formation of the Governor's Youth Advisory Council.

The council has been campaigning that abstinence is the best way to avoid pregnancy.

Winters said birth control measures generally are available to teens, but sex today carries risk of disease, including AIDS.

"With abstinence you are 100 percent sure," she said.

While the report shows a drop in the teen pregnancy rate, it also found that the pregnancy rate among Hispanic girls is about three times the state

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Jennifer Lopez, 17, of Las Vegas, said there are cultural differences in the Hispanic community that contribute to the higher rate.

She also said language barriers prevent some Hispanic girls from reading or acquiring information that would reduce their chances of pregnancy.

Lopez said her support of abstinence has not made her a pariah in her high school.

"I stand up for what I believe in," she said.

The youth council has developed pamphlets "101 Reasons for Abstinence" and "101 Reasons to Say No to Sex" that it has handed out to junior high and high school students statewide. It has plans to distribute abstinence literature to students as young as 10.

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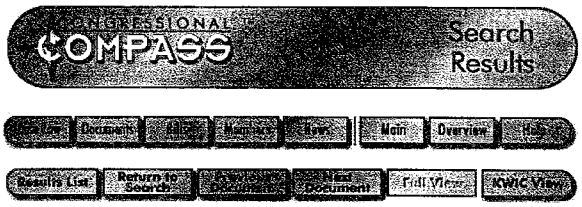


Document 17 of 24.

December 6, 2000

LENGTH: 600 words

HEADLINE: Condoms do not stop all STDs

BYLINE: By Amy Horsman, Daily Evergreen

SOURCE: Washington State U.

DATELINE: Pullman, Wash.

BODY:
Contrary to popular belief, condoms are not a safeguard.

Throughout adolescence we are taught to use condoms to avoid contracting sexually transmitted diseases. Research now suggests some STDs still are easily transmittable even with a condom.

Human papillomavirus, or **HPV,** is contracted through skin-to-skin contact with an infected person by way of oral, anal or vaginal sex.

Intercourse is not necessary.

People can contract **HPV** by touching lesions on an infected person's body. However, lesions are not restricted to the genitals, which is why condoms are only partially effective at providing protection, said Kathryn A. Fort, a nurse practitioner for University of Utah Health and Wellness Services.

There is no cure for **HPV.** The only way to avoid contracting **HPV** is by abstaining from any sexual contact. Fort said little is known about **HPV,** so a vaccine has not been developed.

Fort stressed some lesions cannot be seen by the naked eye. Even if people appear to be uninfected, they could have **HPV.**

HPV is one of the most prevalent STDs. Fort said about 15 million people a year in the United States contract an STD -- one-third are diagnosed with **HPV.**

"It is estimated that men and women who have had sex without a condom with more than one partner have an 80 percent chance of exposure to a strand of **HPV**," Fort said.

Fort attributed the high prevalence of **HPV** to the fact that the infection usually produces no symptoms.

"Most people don't even know they have it," Fort said. The virus still is transmittable without symptoms.

HPV often goes unnoticed and untreated. The virus can only be detected during an outbreak. Fort said the occurrence of outbreaks varies depending on how strong the person's immune system is.

Most students don't realize STD checks do not screen for **HPV.** Fort said women with normal Pap smears who also test negative on STD tests could have **HPV.**

"Pap smears and STD tests give students false reassurance," she said. "Students aren't aware that Pap smears and STD tests are not a complete analysis. We are limited in what we can screen for."

There are at least 80 different strands of **HPV.** Roughly 30 strands of the virus affect the genital region. Non-genital strands of **HPV** are the cause of warts on hands and feet, Fort said.

Genital strands of **HPV** are classified as high-risk and low-risk. High-risk **HPV** usually has no symptoms, but can cause cervical cancer in women if untreated.

If high-risk **HPV** is detected early, cervical cancer can be avoided. Ten percent to 15 percent of genital strands of **HPV** are high-risk. Genital warts are associated more often with low-risk **HPV.**

People can contract more than one strand of genital **HPV.** It is possible to contract both a high-risk and a low-risk strand.

Though the risks are high for women, men also must be aware of the threat of **HPV.** Men can catch **HPV** just as easily as women, and it is harder to detect, said Mary C. Steed, a nurse coordinator for Health and Wellness Services.

Research has not shown **HPV** causes cancer in men, but all other symptoms are apparent.

Steed said men are more frequently coming in to Health and Wellness for treatment, when in the past they did not.

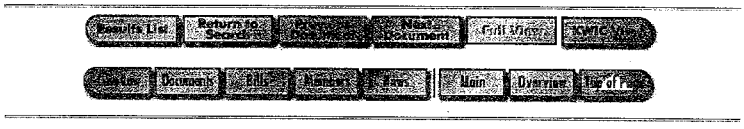
"Men, in general, don't get yearly check-ups, which is why more women may be diagnosed than men," she said.

Fort said little is known about **HPV,** but it is common at Washington State University.

"We see five or six people with **HPV** every day," Steed said.

Students can reduce their risk of getting **HPV** by using condoms and getting tested between relationships.

LOAD-DATE: December 6, 2000



February 7, 2002

The Honorable David M. Walker
Comptroller General of the United States
United States General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Walker,

We are gravely concerned that the federal government may have been involved in promoting an unsafe practice that could have resulted in countless, unnecessary HIV infections throughout the world. Specifically, we are referring to the funding, distribution and promotion of condoms containing nonoxynol-9 by the U.S. government both within the United States and to other countries.

While scientific data released in 2000 in Durban, South Africa concluded that nonoxynol-9 enhances the risk of HIV transmission, this was not new information. A 1989 study showed that the probability of infection occurring was greater among those who used nonoxynol-9 than those in a placebo group who did not. Subsequent to the 1989 publication there have consistently been studies showing this same adverse consequence. According to the study released in South Africa, investigators found that 15 percent of the women using condoms with nonoxynol-9 had become HIV infected.

We would ask you to (1) determine the overall number of condoms containing nonoxynol-9 purchased either directly or indirectly by the federal government through grants to NGOs, states, or international agencies such as UNAIDS or the WHO, and if such distribution is continuing.

Once that has been determined, we would like (2) a calculation of what harm, in terms of new HIV infections, may have been caused through such distribution.

If the U.S. government made thousands, or tens of thousands, of men and women more susceptible to acquiring this disease, then we have done a huge disservice to people throughout

the world. It is, therefore, critically important that a determination be made as to the numbers of people who may have been adversely affected and if this dangerous practice is still ongoing.

We are also interested to know (3) if any efforts were made by the federal government to discourage the use and production of nonoxynol-9 coated contraceptives including condoms, knowing since at least 1989 that nonoxynol-9 was potentially detrimental in terms of HIV risk to the sexual partners of users.

Please also (4) determine the percentage of condoms sold in America and worldwide contain nonoxynol-9 and (5) provide a complete listing of published studies regarding the impact of nonoxynol-9 on HIV risk. We have attached a partial list of these studies for your information.

Thank you for your research into this matter. We look forward to a timely response since numerous lives are potentially at stake in respect to your findings.

Sincerely,

Mark E. Souder
Chair
Subcommittee on Criminal Justice,
Drug Policy and Human Resources

Joseph R. Pitts
Member of Congress

Dave Weldon, M.D.
Member of Congress

Enclosure

Available Studies Regarding HIV Risk of Nonoxynol-9

Nonoxynol-9 (N-9) is a chemical spermicide that has been used to prevent pregnancy for more than 30 years. Some scientists had hoped it might be an effective microbicide against HIV as well, but studies have consistently indicated the opposite for nearly 13 years. The following is a brief summary of the available studies regarding the increased HIV risk associated with the use of N-9.

In 1989, a team led by Joan Kreiss of the University of Washington found that N-9, when used as a contraceptive sponge, was associated with a high incidence of vaginal lesions and genital ulcer-associated HIV seroconversion.

In 1990, the British Columbia Centre for Disease Control reported that genital inflammation and irritation was common among prostitutes, mostly female, who were given condoms lubricated with N-9. The researchers recommended that HIV prevention strategies focus on condoms without spermicides.

In July 1992, the Journal of the American Medical Association published a study authored by Joan Kreiss of the University of Washington and colleagues which found a greater risk of HIV infection associated with the use of N-9.

In August 1998, a study published in the New England Journal of Medicine found that the use of N-9 vaginal film did not reduce the rate of new HIV, gonorrhea or chlamydia infections among female sex workers in Cameroon. N-9 use was associated with higher rates of genital lesions. The study was conducted by Ronald E, Roddy, et. al. of the Epidemiology Unit of Family Health International of Durham, North Carolina.

In 2000, a four year study directed by Lut van Damme, M.D. of the Institute of Tropical Medicine, Antwerp, Belgium, found a 52 percent greater rate of HIV infection among female prostitutes who used a gel containing N-9 than among those who used a placebo gel. The four-year UNAIDS-funded study, known as COL-1492, involved 990 women. The women received counseling and condoms. Fifteen percent of the women who received N-9 became infected with HIV.

In September 2000, a study published in the issue of Contraception conducted by Dr. David M. Phillips and colleagues found that N-9-containing products cause rapid exfoliation of epithelial cells during rectal intercourse, which increases the likelihood of HIV and HSV-2 infection.

A study published in the August 15, 2001 issue of the Journal of Infectious Diseases authored by Dr. Deborah J. Anderson of Brigham and Women's Hospital in Boston and colleagues found that N-9 increases the risk of HIV-1 transmission by causing inflammation of cervicovaginal epithelial cells.

Mr. BILIRAKIS. Without objection.

Mr. PITTS Abstinence education has proven effective in reducing the rate of sexual activity among teens. As Members of the House, we have a duty to ensure that we are not sending mixed messages to our youth. I look forward to hearing from the witnesses today on abstinence only education and would encourage my colleagues to reaffirm our commitment to abstinence only education, support the reauthorization, Title V, abstinence block grants in the interest of protecting and preserving the health of our Nation's children. I yield back the balance of my time.

Mr. BILIRAKIS. I thank you, Mr. Pitts. Ms. Harman, for an opening statement?

Ms. HARMAN. Well, thank you, Mr. Chairman. I didn't expect to offer one, so I'll wait until the questioning period. Thank you very much.

Mr. BILIRAKIS. Thank you very much. Mr. Greenwood, for an opening statement.

Mr. GREENWOOD. Thank you, Mr. Chairman. I'll be very brief. I have two daughters, 15 and 16½. I am more interested in abstinence than I've ever been interested in it in my life right now.

And I believe that any sex education that doesn't talk about abstinence is poor sex education indeed. If you don't talk about the fact that abstinence is the only way to be certain to avoid pregnancy and sexually transmitted diseases, you do a disservice to children. Certainly, if you implicitly or otherwise promote sexual activity among teenagers, I think you do a disservice to children.

My concern is I think you do a disservice to children when that's all that you tell them. That's certainly not all that my wife and tell our daughters because we want our daughters to understand how their bodies work. We want them to understand how male bodies work. We want them to understand how they work together and then we want them to understand why it is in their interest to abstain from sex until they're in a committed and hopefully married relationship. But I am so interested in abstinence that I think we ought to spend Federal dollars to teach abstinence, but since we don't spend any Federal dollars to teach sex education in the schools at all, I think we need to teach both. And I think it's a no brainer. And I don't know what we're fighting about. But I look forward to fighting about it.

Mr. BILIRAKIS. I believe that completes the opening statements of all the people who are present. That being the case, we'll go right into the Panel.

First, I would ask unanimous consent that a letter which has been shared with the minority, dated April 23 from Secretary Thompson to Chairman Tauzin regarding this issue and the fact that the administration supports a 5-year reauthorization of the abstinence program and also is a strong supporter of the 1-year reauthorization of Transitional Medical Assistance, I ask unanimous consent that it be admitted into the record.

There's a letter here from Mr. Rick Pollack, Executive Vice President of the American Hospital Association, dated April 19th, advancing health in America, dated April 19th. I ask unanimous consent that be made part of the record.

We'll go into our Panel then. Ms. Jacqueline Del Rosario resides in Miami, Florida. Dr. Joe S. McIlhaney, The Medical Institute for Sexual Health, Austin, Texas. Dr. David W. Kaplan is head of the Adolescent Medicine and Professor of Pediatrics, University of Colorado School of Medicine. Dr. Cindy Mann, a Senior Fellow with the Kaiser Commission on Medicaid and the Uninsured. And Dr. William J. Scanlon, Director of Health Care Issues with General Accounting Office. We've had the honor and pleasure of having Mr. Scanlon here many times. It's awfully nice to see you, sir and we will start off with Ms. Del Rosario. We set the clock at 5 minutes. If you haven't quite completed your statement, I certainly won't cut you off. Please proceed.

STATEMENTS OF JACQUELINE JONES DEL ROSARIO, EXECUTIVE DIRECTOR, RECAPTURING THE VISION INTERNATIONAL; JOE S. McILHANEY, JR., THE MEDICAL INSTITUTE FOR SEXUAL HEALTH; DAVID W. KAPLAN, HEAD OF ADOLESCENT MEDICINE, PROFESSOR OF PEDIATRICS, UNIVERSITY OF COLORADO SCHOOL OF MEDICINE; CINDY MANN, SENIOR FELLOW, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED; AND WILLIAM J. SCANLON, DIRECTOR, HEALTH CARE ISSUES, U.S. GENERAL ACCOUNTING OFFICE

Ms. ROSARIO. Thank you. Thank you for inviting me to share today. I believe that I will bring a very unique perspective on the issue of abstinence education. As I began to do my research for my presentation I was very surprised to find that there's just tons of documentation of studies and evaluations that have been conducted. There are many that say that abstinence only education is successful. There are others that say it is not. It just depends on what side of the field that you're standing on.

I was much more of a skeptic when I entered the field. When I worked with teens at the middle and high school levels what I found was that they have very, very different views of sex. It was not because of a revolution, but they were very base in action. Wanting to have sex, my challenge was telling kids well, you want to postpone that, you don't want to get pregnant. You want to preserve your education? Why? Because it's going to give you a better life. Well, no, my mom had me at 17. My grandmother had her at 18. Or that they have a boyfriend that they want to give a baby to. I mean these are the issues that I don't think that condom distribution really is going to be able to impact.

One day I was delivering a lesson with the students discussing various issues and I was asking what do some of these statements, what message do they send to you? One was sex outside of marriage, the other was condom distribution or contraceptions in schools. Unanimously, kids that had just earlier stated I'm not considering being abstinent, others saying that they were, unanimously all of them stated that I believe that this message tells them that adults are saying that they're not going to be able to abstain from sex, you're going to do it and it's okay as long as you protect yourself.

I quickly became a very ardent believer in the abstinence message. This is because I find that kids do want a very clear and con-

cise message and I was surprised to find that many want to take the high road. I think that as roads we have to encourage them to raise a standard, but more than that, I believe that the abstinence funding allows us to really build human character.

For the first time, we're really able to use these dollars to build the individual that's going to continue to keep our Nation strong. And I think that we're talking about the subculture that's developing in the United States of America. Kids have mixed values. They're very confused. And I think that we have to begin to be surrogates to help to strengthen the families, to keep kids dreaming about their futures and believing in life as a possibility. And that's what I found to be the purpose of abstinence education.

As I said before my research, I found that there were studies that proved that abstinence was successful, others that said that it was not. I have looked at several issues concerning this, however. In our state, sex education is taught in the schools. Currently, 9 out of 10 schools out of the 2 million nationwide do teach a comprehensive sex education course. In addition to that Title X funding has not been decreased to make room for abstinence education. The funding in our State level is $15.2 million, $8 million of that is given at the State level for Title V abstinence education; 4 of that $8 million is a match from the State.

Despite these things happening, I think that we're able to see that there has not been a significant change in the trends of sexual behaviors, nor has there been a decline really in pregnancy rates over the 30 years that Title X funding has been given. I think that we've seen a decrease over the past 10 years and many will say, according to the argument that abstinence education profoundly has impacted that. Others might say that it has not.

But I would ask you to consider today the plight of America's youth. As I look at some of the attitudes that I'm witnessing in the classrooms, I'm concerned. I'm concerned because it's not about Johnny loving Sally any more. It's about the subculture. It's about a lifestyle and we need programs that are going to enable us to teach to the whole person, not to the behavior, bandaid approach that we're going to apply a condom or use a contraceptive over the genitalia, but what's going to protect the dignity. I'm interested in building the fiber of our Nation one individual at a time and I think that abstinence education allows us to do that with the young people of this Nation. And I think to circumvent that would be to abate progress.

Recapturing the Vision has been in existence for 8 years. We've enjoyed funding that was not under Title V, but we've also had funding under Title V education dollars and our program to date has a success rate of 99.9 percent. Let me give you a picture of the type of citizens that we work with. Basically, 65 percent of those that we serve are on public assistance. They are intergenerational kids outside of wedlock. In other words, they are the offspring of the offspring of the offspring of a teen parent.

They are receiving sex education, but they have a mindset that does not even make them sometimes want to avoid pregnancy. What I found in my dealing with this population is that they're wanting us to believe in them and they're wanting us to furnish them with the skills to support the high road. I think that many

kids are taking the high road. Of the 52 high school age students that are sexually active, remember that there's 48 percent that are not. But even of those 52 percent that are, I think that we can still let them know that they need to take the high road. Abstinence education teaches to the psychological situations and circumstances to early sexual involvement outside of marriage.

It gives them the skills that they need to be able to support this decision to remain abstinent. I'm talking about character development. I'm talking about conflict resolution skills, negotiation skills, refusal skills. I'm talking about the understanding and building of value for marriage and family. It's that simple.

This is America today. Some of the subcultures that we're seeing now are transcending the 'hood. They're moving into suburbia and I think that they're getting so many messages about condoms and safe sex and all of those things, abstinence represents one voice in a crowd of many. Last week I was watching MTV. They were talking about safe sex and condoms. Abstinence represents a very small voice. It's one voice that cannot be snuffed out. It's a voice, I believe that's going to do more than just prevent teen pregnancies, but it's going to be able to build strong citizens for our Nation.

Thank you.

[The prepared statement of Jacqueline Jones Del Rosario follows:]

PREPARED STATEMENT OF JACQUELINE DEL ROSARIO

Introduction

I am Jacqueline Jones Del Rosario, Executive Director of *ReCapturing the Vision International,* a non-profit organization working in the field of abstinence-only education since 1994. I would like to share my unique experience in the area of abstinence and Title V Funding.

I initiated abstinence-only education purely as a skeptic. I believed that teens from strong families or those with strong religious convictions could perhaps be taught to delay sex until marriage because I believed that our message merely reinforced the same message these children received from strong home environments. I did not believe, however, that the masses of at-risk teens from impoverished backgrounds could adhere to the abstinence message. After all, many of them could not understand why they should avoid getting pregnant before graduating.

In the beginning years of *ReCapturing the Vision,* I was teaching a group of thirty students at Madison Middle School. This school is located in a dilapidated area of Miami-Dade County. Over 80% of the students enrolled received free or reduced priced lunches each day. This school had been rated a "D" school under the criteria established by Governor Jeb Bush.

In the lesson that I was delivering that day, we reviewed pages from the *Capturing the Vision* textbook. The students were asked to explain what messages do the following actions send: lying, sex outside of marriage and the distribution of birth control in school. I received an awakening when the students unanimously responded that the message they gathered from the distribution of condoms was that adults expected them to have sex, but only asked them to use protection. In the student's minds, this action represented consent, as long as protection was used.

The answer from this population was riveting. I had heard it said that abstinence with contraceptives was a "mixed message" but I never believed it to be true. Kids need a concise and clear message. To hear it from the students caused me to believe that we must be the voice that tells them that we expect them to abstain and we believe they can do it.

Sex Education is Being Taught in 91% of Schools

According to a recent Kaiser Family Foundation Study, nine out of ten (89%) of the nation's nearly 20 million public secondary schools teach sex education (Kaiser Family Foundation, Sex Education in America: A Series of National Surveys of Students, Parents, Teachers, and Principals. September 2000). This holds true in

Miami-Dade and Broward counties where the students receive sex education involving information on contraceptives and STD's including HIV. However, at the onset of our program, less than 10% of those who received this education knew what abstinence meant.

Through this, *ReCapturing the Vision* has realized that sex for today's generation is different from when our parents dealt with it during their adolescence. No longer is sex an expression of love; it has evolved as a social trend, and because of this, *ReCapturing the Vision* has become that one voice that encourages kids that they do not need to have sex, nor do they have to. *ReCapturing the Vision* teaches the consequences of sexual involvement and educates students on STD's, but most of all; we build personal value and foster the vested interest that kids need take into their futures.

In 1999, a nationwide study of principals discovered that 58% describe their school's sex education curriculum as comprehensive, teaching that "young people should wait to have sex but if they do not, they should use birth control and practice safer sex." On the contrary, only 34% say that they offer abstinence-only education teaching "young people should only have sex when they are married" (Kaiser Family Foundation, Sex Education in America: A Series of National Surveys of Students, Parents, Teachers, and Principals. September 2000).

According to the 2000 Federal School Health Education Profiles study, the median percentage of schools offering required health education courses to students in grades 6 through 12 was 91%. Among these schools, a large percentage said that they tried to increase knowledge of HIV (96%) and teenage pregnancy prevention (84%) (Centers for Disease Control and Prevention, Guidelines for Effective School Health Education to Prevent the Spread of AIDS, MMWR 37 (S-2): 1-14, January 29, 1988).

If the pregnancy rate for Dade County were calculated for 445 students, RTV would expect 8.12 births to girls under the age of 19, despite the fact that children receive at least one sexual education course between grades 6 and 12. *ReCapturing the Vision* has served over 5,500 at-risk teens over the past eight years and only one participant has become pregnant during that time period. It is clear that abstinence-only education can make in impact in our city.

As a program currently being evaluated under Title V by Mathematica Policy Research and locally at the state level, we are certain that the findings of these evaluations will only support what we have found to be true through internal evaluation. We have found that abstinence education is effective, not only in the lives of mainstream youth, but for at-risk teens as well.

Title X Funding Has Not Produced Results

The 1970's produced an increase in the birthrate of unmarried adolescents by 23.8%. The 1980s, increased to 52.3%. In the 1990's however, the birth rate to unmarried adolescents increased only by 4.5%.

The Title X funding expansion initiated the safe sex movement in the 1970s, and was followed by an increased growth rate in abortions, births to unmarried teens and premarital sex by teenagers. In the 80's Title X funding was decreased, and following that cut was a reduction in the growth rates of abortion and unwed births. Title X dollars proved that contraception distribution and the "safe sex" message was not effective, but was creating an environment to breed an increase in teen sexual activity.

In the 1990s privately funded abstinence programs worked to change the tide, while Title X continued to teach the safe sex message. The 1990s showed a dramatic decrease in the growth trend of birth rates to unwed teens, increasing only by 4.5%. It would be illogical to attribute such an improvement to the Title X initiative, when the previous 20 years have proven that Title X programs have consistently produced opposite results.

The rise in abstinence programs in the 1990s has produced this change in trends. The growing abstinence-only message coincides with the improvement in the data reflecting adolescent sexual behavior. Abstinence programs are extremely effective. In 1982 through 1987, an abstinence program implemented in Denmark, SC reduced teen pregnancy by 59%. In the 1990s, the implementation of an abstinence-only curriculum in Washington, D.C. reported a pregnancy rate of 1.1%. ReCapturing the Vision in Miami-Dade and Broward Counties in Florida show a 1.1% teen pregnancy rate in eight years of service provision to the public.

It is likely that the increase in the abstinence message is directly responsible for the improvement in the positive trend in adolescent sexual behavior recorded in recent years. It is safe to assess that these improvements would have been much greater if the allocated Title X dollars during the 1990s had been devoted to abstinence only education.

Evaluating Strong, Not Weak, Abstinence Programs

I have noted that there exists a definite conflict in most of the studies being conducted on abstinence-only education. Most do not measure up to the abstinence definition. That is to say, most of the programs being evaluated do not teach the eight points outlined in the Title V Social Security Act. This issue has been brought to the forefront of the current evaluation being conducted by Mathematica Policy Research. Those in the field have voiced their concerns that the programs being evaluated should be strong and solid programs, fulfilling congressional guidelines for abstinence education. There is a great variation among current programs being evaluated at the state levels. Some programs consist of five or more presentations. Their focus is to merely teach teens to say no to sex before marriage. These programs are not comprehensive and they do not contain the elements of most successful abstinence programs. According to *A National Strategy to Prevent Teen Pregnancy, Annual Report 1998-99, U.S. Department of Health and Human Services, 1999,* the following are five "Key Principles" that should be featured in successful abstinence programs:

1. *Parental and Adult Involvement.* Parents and other adult mentors must play key roles in encouraging young adults to avoid early pregnancy and stay in school.
2. *Abstinence.* Abstinence and personal responsibility must be the primary message of prevention programs.
3. *Clear Strategies for the Future.* Young people must be given clear connections and pathways to college or jobs that give them hope and a reason to stay in school and avoid pregnancy.
4. *Community Involvement.* Public and private sector partners throughout the surrounding areas—including parents, schools, business, media, health and human service providers, and religious organizations—must work together to develop comprehensive strategies.
5. *Sustained Commitment.* Real success requires a sustained commitment to the young person over a long period of time.

If we are to examine the issue to arrive at the truth, again I must restate, strong and solid programming must be the basis of all evaluations.

ReCapturing the Vision, An Abstinence Program for Youth

ReCapturing the Vision does not just teach teens to say no to sex, but we also build their values and cause them to embrace the future. RTV embodies all five of these elements. As a result, "no" becomes a natural response. Building peer groups and educating parents on how to communicate with their teens on sexual issues has also made a great impact. Many parents have initially stated that they don't tell their kids to abstain. Rather, they state in a greater frequency that protection is imperative. Improving teen/parent communication has strengthened the clear message that teens are receiving about sex and parental expectations.

RTV is a holistic, multi-tier program providing abstinence strategies through a three-tier service delivery: school, home and the community. In the context of the school, RTV addresses the whole participant, building self-esteem, developing character, and providing information and skills to make positive choices. The program is delivered as an elective course during the regular school day. Students receive daily instruction throughout the entire school year. Our goal is to address the root issues of youth behaviors versus attempting to protect them from those risky behaviors.

In the context of the home, RTV integrates the parent and family into the scope of service. Trained social workers make monthly home visits and conduct casework including counseling, referral services and parent training. Family mentoring spawns from this tier of service and involves families of the highest need in intensive three-day excursions that take place outside of their current environment. Families are immersed in bonding type activities and receive training to build the family structure and unity.

The community brings the third and final level of intervention through after school programs delivered through partnerships with local churches and community based organizations that are in the feeder patterns of the schools that we serve; thereby offering students positive activities and opportunities for remediation during critical after school hours.

Large-scale community events take the abstinence message community wide as significant community entities are educated on the importance of abstinence and the role they can play in the fight. These events include conferences, concerts, rallies and training workshops.

RTV Success Rates

Through RTV's philosophy of addressing the whole child, versus merely teaching them to say no, consistent data clearly documents the inroads that we have made in changing teen attitudes and behaviors:

- 100% of students enrolled demonstrate increased self-esteem as assessed by an attitudinal survey.
- 89% of students improved behavior as evidenced by a decrease in outdoor suspensions and 80% in indoor suspensions.
- RTV has a 99.99% success rate in preventing teenage pregnancies among students actively involved in the program for one year.
- 60% of students improved attendance
- 75% improved academic performance as indicated by an increase in grade point averages.

The Economic Implications Equal Mindsets

Economics play a strong role in sexual behaviors and trends. The pregnancy rates for non-Hispanic black and Hispanic teenagers are about twice as high as non-Hispanic white teenagers. The lower pregnancy rates are due to differences between groups in economic opportunity and family stability (National Vital Statistics Reports, Vol. 47, No. 29, December 15, 1999).

In 1995, 57% of non-Hispanic black teenagers and 52% of Hispanic teenagers compared to 46% non-Hispanic white teenagers are sexually active. About 1 in 3 sexually active black and Hispanic teenagers became pregnant in 1995, compared with about 1 out of 6 sexually active non-Hispanic white teenagers. The differences in sexually activity and pregnancy are associated in part with differences between groups in economic opportunities and family stability.

Condoms cannot address the social ills that plague our nation, but abstinence can. Pregnancy rates are economically derived (Wilson, W.J. The Truly Disadvantaged: The Inner City, The Underclass, and Public Policy. University of Chicago Press. Chicago. 1987). Many children from impoverished backgrounds do not even have the desire to avoid teenage pregnancy. In fact, many desire to have a child and see the birth of a baby as a direct link to public assistance. In many inner city neighborhoods, early sexual activity and teenage pregnancies has become a lifestyle. I have seen first hand the influence that economics play in sexual attitudes. An alarming truth that was uncovered during my labor in the field is that nearly 45-50% of the participants we serve have no value for marriage or the family. They have never seen a wedding and live in a home with a single parent and that parent's live-in companion. Many do not have negative ideas about teenage pregnancy and do not see it is a danger to their future, but rather, a way of life in their world. Abstinence-only education is the weapon that can fight in this war.

As a nation, we need to be about addressing the behaviors versus applying the band-aid to the behavior. In this case, this is what contraceptives represent. Sadly enough, however, if a child does not deem avoiding teenage pregnancy a worthy cause, they will never use contraceptives as a means to prevent something that is not perceived as being a threat to their future. Abstinence is a necessary extension of welfare reform. It is a means to elevate the mindset of at-risk populations who are not engaging in sexual intercourse because Sally loves Johnny, but because it is a part of the behaviors that this subculture has adopted. This scenario has weakened the fiber of our nation as generational cycles of teen pregnancy and poverty threaten our stance as a national power.

Contraceptives cannot protect a 15-year-old from the erosion of her dignity and self-worth. There must be another value that causes teens to raise their standards and protect their emotional and physical health. This message is embodied in the plan defining abstinence-only education. Title X Funding has not undergone the same scrutiny but has received funding for the past 30 years. Abstinence-only deserves an opportunity to demonstrate its impact in the field.

RTV is developing teens that are abstaining from premarital sex, remaining in school, and even better, improving their grades and behavior as evidenced by improved GPA and reduced suspensions. They are learning to work for success and to protect their futures. We are fostering teens that may be the first in several generations to become self-reliant and support themselves versus a life on and off public assistance. They are the core of a better nation. Their offspring will receive a perception quite different from that of their parents and grandparents. They won't be the product of a single family nor will they be 50% more likely to be involved in criminal behavior. They will have a good start in life and will manifest a true turn of the tides of teenage pregnancy.

Mr. BILIRAKIS. Thank you very much, Ms. Del Rosario.

Dr. McIlhaney? Please, pull the mike closer. Obviously, your written statements are part of the record and we would hope that you would—Ms. Del Rosario did complement or supplement it, if you will. Please, Doctor, go ahead.

STATEMENT OF JOE S. McILHANEY, JR.

Mr. MCILHANEY. Thank you, Mr. Chairman, and distinguished members. I'm a gynecologist who practiced medicine for 28 years. I had a rewarding practice, caring for infertile women, doing in vitro fertilization, taking care of lots of adolescents. I left my practice to commit the remainder of my medical career to helping prevent two of the problems that I saw hurting my patients the most, the out-of-wedlock pregnancy and sexually transmitted disease problems. And today, I'm president of the Medical Institute for Sexual Health, a nonprofit medical educational organization which I founded in 1992.

In 1996, I testified on the proposed Welfare Reform Act. My message then was that sexually transmitted disease and nonmarital pregnancy are much, much more common than most Members of Congress and most Americans realize. To its credit, Congress provided funding that has helped more than 700 abstinence programs around the country devoting serious and much needed attention to these problems.

The good news today is that since 1990, the number of teens becoming sexually active and the number of teens becoming pregnant has been declining so that today more than half of teens in high school across, high schools across the country are still virgins and we have the lowest teen birth rate that we've had since the 1950's as this first chart shows.

It's reasonable to conclude that one factor contributing to this improvement has been the concombinant rise in abstinence education programs, there's some specific programs, as a matter of fact, such as the one in Monroe County, New York and others that have actually found declining teen pregnancy rates as a result of their education programs. But the bad news is that 25 percent of teens are infected with a sexually transmitted disease. There are 3 to 4 million teens that get a new sexually transmitted disease every year. In addition, the epidemic has evolved to a new and more dangerous epidemic, no longer gonorrhea and syphilis which are treatable with a shot of penicillin, but now we have an epidemic of viral diseases. HPV which is human papillomavirus, herpes, HIV, and we've never cured any human viral infection.

One study shows that 50 percent, half of sexually active 15 to 20 year olds are infected with human papillomavirus. Approximately 6 percent of teenagers are infected with genital herpes. Then there's chlamydia which is dangerous because it's so common in teens. It's rarely symptomatic and it causes infertility. Twelve percent of 17 year old female Army recruits were found to be infected with chlamydia on induction and they didn't know it.

Today, 1 in 4 adolescents is infected with an STD. Today, there are more diseases, 25 sexually transmitted diseases as opposed to 2 when I started medical practice back in 1968. Today, the diseases that are most dominant are viral diseases and with no cure. And there is no evidence, for example, that condom reduces sexual

transmission of the common sexually transmitted disease which is human papillomavirus because it's 99 percent of all cervical cancer, killing more women than AIDS kills and causing almost all abnormal Pap smears and there's an epidemic of abnormal Pap smears among teenagers today, when I saw almost no adolescents with abnormal Paps when I started practicing in 1968.

One reason STDs have become so common among teenagers is that the younger age of sexual initiation is happening. The more sexual partners, as a matter of fact, that teens tend to have is associated with or beginning sexual activity at a younger age as this next chart shows. The biggest risk for becoming STD-infected is how many sexual partners you or I have had in our lifetime. Even though the pregnancy rate among teens has declined, as I mentioned, a devastating trend has developed. Whereas in 1960, 15 percent of teen births were to unmarried teens. Today, 78 percent of teen births are out of wedlock. There seems to be a resurgence of insistence that so-called abstinence plus or dual message programs, discussing abstinence while also teaching all about contraception, that these are the solution to these epidemics. But let me remind you that for many years these programs were the predominant approach for sexuality education in this country. These programs, as a matter of fact, were almost unchallenged during the 1980's and it was during those years that the problem I've just outlined grew the most. As a matter of fact, it was during those years when my attention was grabbed by what was happening to my patients and what I saw in research literature. In addition, these programs developed and were studied extensively by the most prestigious academic institutions in America.

Let me remind you that what those studies show. Only a handful of these programs and there are multitudes of them have shown any significant impact on any behavioral or health outcome. Only two of the Centers for Disease Control's "Programs That Work" have reported statistically significant delays in the initiation of sexual activity and only one of those has reported a truly substantial impact on this delay of sexual activity. Not one of those CDC programs has studied the incidents of sexually transmitted disease or of pregnancy rates in kids that were exposed to those education programs.

Much has been made of reports that parents want their children to have dual message programs. None of these surveys included parents who have been given even as little information as I have provided you today about how often condoms and contraceptives fail and how prevalent diseases have become. I believe parents would want a vigorous effective abstinence education program for their children if they knew the facts, even that I've provided you today.

There's abundant evidence that the safer sex paradigm has not solved the problem. As a matter of fact, Doug Kirby who is a well-known advocate of safer sex programs, if we would put up the next chart, after he did extensive research of the sexuality programs said it may actually be easier to delay the onset of intercourse than to increase contraceptive use.

We recognize that we not yet have sufficient data to positively determine the degree of effectiveness of abstinence education, but results are promising.

Mr. BILIRAKIS. Please summarize.

Mr. MCILHANEY. I have just about two more sentences. The National Evaluation of Abstinence Programs of Mathematica will be completed in the year 2005. If we don't continue with the current level of funding or if we change the focus of the programs funded, for example, by changing the A through H definitions, we'll lose an invaluable opportunity to learn how we can effectively help young people avoid sexual activity, at risk behavior at least as detrimental to their health as the use of alcohol drugs and tobacco.

Thank you very much.

[The prepared statement of Joe S. McIlhaney, Jr. follows:]

PREPARED STATEMENT OF JOE S. MCILHANEY, JR., PRESIDENT, THE MEDICAL INSTITUTE FOR SEXUAL HEALTH

Thank you, Chairman Bilirakis and distinguished members of the Subcommittee.

I am a gynecologist who practiced medicine for twenty-eight years. I had a rewarding practice of in vitro fertilization and surgery, but I left my practice to commit the remainder of my medical career to helping prevent two of the most profound medical problems of our day, out-of-wedlock pregnancy and sexually transmitted disease. I have been doing this through an organization called The Medical Institute for Sexual Health, which I founded in 1992. The mission of the Medical Institute for Sexual Health is to identify, evaluate and communicate credible scientific data in practical, understandable and dynamic formats to promote healthy sexual decisions and behavior in order to dramatically improve the welfare of individuals and society.

THE GOOD NEWS

In 1996, I testified before the House Ways and Means Subcommittee on Human Resources on the proposed Welfare Reform Act. My message then was that sexually transmitted disease and non-marital pregnancy are hurting far more people in society than most members of Congress and other Americans realize. To its credit, in an effort to constructively and meaningfully deal with these pregnancy and disease problems, Congress funded abstinence education with $50 million a year for five years through the Title V provision of the Welfare Reform Act. This funding has helped more than 700 abstinence education programs around the country to devote serious and much needed attention to these problems.

I come today with good news and bad news. The good news is that there is credible evidence showing that abstinence education is having an impact. More young people are living an abstinent lifestyle, and fewer teens are becoming pregnant. Today, more than half of all high school students are virgins.[1] Also, beginning in 1990, the number of teens becoming pregnant began declining. Today we have the lowest teen birth rate that we have had since the 1950s, and teen pregnancy rates are lower than they have been any time since 1976.[2,3]

A ray of light and hope is emerging. Trend data showing declining sexual activity among adolescents and declining teen pregnancy rates reveal a societal shift in a positive direction—it is reasonable to conclude that one contributing factor is the concomitant rise in abstinence education programs, though how large of a contributing factor we do not know. Some specific programs, such as the one in Monroe County, New York, and the Best Friends program that began in inner city Washington, DC, show a very marked decline in pregnancy rates.[4,5]

THE BAD NEWS

But the bad news is that we still have an enormous problem. Sexually transmitted infection is highly prevalent among adolescents. Three to four million STDs are contracted yearly by 15 to 19 year-olds, and another five to six million STDs are contracted annually by 20 to 24 year-olds.[6] Approximately six percent of adolescent females tested at family planning clinics and nine percent of female U.S. Army recruits (12.2% of 17 year-olds) are infected with *Chlamydia trachomatis*.[7,8] 5.6% of 12 to 19 year-olds and 17% of 20 to 29 year-olds are infected with herpes simplex virus type 2 (the virus that causes genital herpes).[9] And whereas in the 1960s, only

two STDs were of real concern, we are now aware of more than 25 (Appendix A). It is clear that, if and when young people begin sexual activity prior to marriage, they are at very high risk of acquiring an STD.

One reason STDs have become so prevalent among young people is that, in spite of the recent trend toward later sexual initiation, we had for years been experiencing a trend toward earlier sexual initiation, and the trend toward later marriage continues.[10,11] The combination of these two factors means that people are likely to be single and sexually active for a significant period of time—5 to 10 years or longer—during which they will normally accumulate a number of sexual partners. In fact, age of sexual onset is a very strong predictor of lifetime number of sexual partners.[12] And an individual's risk of ever having contracted a sexually transmitted disease is strongly linked to his or her lifetime number of sexual partners.[13,14,15]

In addition, a major shift has occurred over the past three decades. The diseases primarily infecting young people are no longer syphilis and gonorrhea, which are frequently symptomatic and treatable with penicillin, but viral diseases such as human papillomavirus (HPV), herpes, and the unusual bacterium, chlamydia. The viral diseases cannot be cured—only managed. And chlamydia, a major cause of infertility in young women, is asymptomatic in up to 85% of infected women [16] but can still cause significant problems even without the presence of noticeable symptoms.

The sexually transmitted disease that has become the most common is a virus called human papillomavirus (HPV). The most recent major study about young women and HPV shows that 50% of sexually active women between the ages of 18 and 22 are infected with HPV.[17,18] The National Institutes of Health Workshop On The Scientific Evidence On Condom Effectiveness For STD Prevention reported that there is no evidence that condoms reduce the sexual transmission of this infection.[19] The NIH report also found no evidence for risk reduction for the transmission of herpes. A recent study has shown that condom use can produce a significant reduction (but not elimination) in the risk of herpes acquisition by women; however, the study did not find any impact for men.[20] In addition, researchers at Johns Hopkins University, upon completing a study of STD prevalence at an adolescent clinic, found re-infection rates of chlamydia in adolescent girls to be so high that they recommended testing every sexually active adolescent girl in the United States every six months for chlamydia infection (regardless of reported condom use).[21]

Even though the pregnancy rate among teens has declined, today, 78% of teen births are out-of-wedlock, compared to 15% in 1960.[22] These out-of-wedlock births contribute to poverty, crime, and negative outcomes for children including physical and emotional health problems, and educational failure. For example:

1. Poverty—In 1995, 66% of families with children headed by a never-married single parent were living in poverty.[23]
2. Child health "White infants born to unmarried mothers are 70% more likely to die in infancy. Black infants born to unmarried mothers are 40% more likely to die.[24]
3. Education—Living in a single-parent family approximately doubles the likelihood that a child will become a high-school dropout.[25]
4. Crime—Boys raised in single-parent homes are twice as likely to commit a crime that leads to incarceration by their early thirties.[26]

"ABSTINENCE PLUS" EDUCATION IS NOT THE ANSWER

Many have suggested that so-called "abstinence plus"—dual message programs discussing abstinence while also teaching all about contraception—is the appropriate answer to the twin epidemics of sexually transmitted diseases and out-of-wedlock pregnancies. Yet, for many years, it is just such programs that have been the predominant approach of sexuality education. And what did we see during these years? A genuine epidemic of sexually transmitted diseases is devastating our young people.

There have been many studies of dual message educational programs. Only a handful of these studies have found any significant impact on ANY behavioral or health outcome.[27] And most of these have only made "statistically significant" impacts on behavioral outcomes (many times of questionable practical significance—such as "condom use at last intercourse" and "frequency of unprotected sex" in the past few months). Only two of the CDC's "Programs That Work" have reported statistically significant delays in the initiation of sexual activity, and only one of these has reported a truly substantial impact on this outcome.[28,29] Recently and to the acclaim of the media, a study reported a reduction in pregnancy rates among participants in a teen pregnancy prevention program. The intervention made no impact

on rates of sexual activity and did not even measure STD rates. And the impact on teen pregnancy was almost entirely attributable to injectable contraception use, which provides NO risk reduction for HIV or any other STD.[30] Additionally, this intervention was so expensive, per student, that it cannot be considered a reasonable option in most settings. Finally, not a single one of the CDC's so-called "Programs That Work" has even investigated its impact on STD or pregnancy rates![31]

Despite what you may sometimes hear, there is no abundance of evidence that "dual message" or "comprehensive" programs are effective at preventing teen pregnancies and STDs. In fact, there is precious little evidence that these programs are really successful at all. Proponents of dual message programs face the same problems today as they have for many years—an inability to document tangible success in protecting adolescent health. And to whatever extent these programs give young people the impression that "sex is really not a big concern, as long as you 'protect yourself'," such programs may even contribute to the problem.

Additionally, "safer sex" programs do not even address the problem of *out-of-wedlock* pregnancy. At best, these programs may encourage young people to wait before having sex; but there is rarely if ever any mention of the importance of actually being abstinent UNTIL MARRIAGE. As I have already stated, in spite of the recent decline in teen pregnancy rates, there has been a steady increase in the proportion of teen births occurring to unmarried teens. Similarly, the proportion of all births occurring out of wedlock has risen dramatically in the past few decades, so that in 1999, 33% of all American births occurred to unmarried women (compared to just 18% in 1980)[32]. Could this increase be related to the lack of an emphasis on marriage in our classrooms over that period? It has only been in the past few years that this trend has begun leveling off, but certainly there must be a much greater emphasis placed on abstinence *until* marriage, not just until some unspecified later date—an emphasis that is clearly required by the Section 510 definition of abstinence education.

Much has been made of the fact that many parents and sexuality education teachers believe it is necessary, as an element of public sexuality education, to teach kids very directly how to use condoms and contraceptives. Clearly, parents care about their adolescent children and desperately want to protect them from harm. Unfortunately, far too many parents are inadequately informed about the problems of contraceptive and condom use. How many parents know, for example, that condoms do not appear to reduce the risk of infection with human papillomavirus, which is the cause of almost all cervical cancer and most abnormal Pap smears? Do most parents understand that even with 100% consistent condom use, their sexually active adolescents are at risk of contracting one of the other prevalent STDs (gonorrhea, chlamydia, trichomoniasis, etc. . . .)? Do parents understand that, for many sexually transmitted diseases, if condoms are not used 100% of the time it is little or no better than not using a condom at all, ever?[33] If America's parents knew the facts—and these are scientifically supported facts, not conjecture nor ideology—we know they would agree with us: Their children need to hear that the only reliable way to protect themselves from a sexually transmitted disease that can have lifelong, physically and emotionally painful ramifications, is to abstain from sexual activity.

MARRIAGE IS A HEALTH ISSUE

Title V clearly articulates an abstinence-until-marriage message. Marriage involves both personal and public health issues. An individual's number of sexual partners is directly linked to his or her risk of contracting a sexually transmitted disease. The one environment where people are most likely to have one sexual partner for a long period of time is marriage. The largest study ever done examining sex in America was conducted by researchers at the University of Chicago and published in the aptly named book, *Sex in America*.[34] These researchers reported that, in contrast to what most Americans believe, when a marriage is intact, married couples almost never have sex outside of that marital relationship. Young people should be encouraged to maximize their own personal health by reserving sexual activity for marriage.

CONCLUSION

With STD prevalence among young people continuing at high levels, condoms clearly not *eliminating* the risk of any STD, and a continued increase in the proportion of births occurring to unmarried mothers, there is abundant evidence that the "safer sex" paradigm, despite more than 20 years and a variety of education programs designed to promote condom use, has not solved the problem. Since new research is beginning to suggest that abstinence education can effectively address these problems, it is important that we continue the effort begun in 1996 and allow

these programs sufficient time to continue to prove their effectiveness. Title V, including the definitions A through H, must be maintained as is. Doing so will ensure that research and evaluation can continue so that we can learn how this option is best delivered, and how abstinence education can best protect young people.

We recognize that we do not yet have sufficient data to positively determine the degree of effectiveness of abstinence education. But results are promising. The national evaluation of abstinence programs by Mathematica will be completed in 2005. If we do not continue with the current level of funding, or if we change the focus of the programs funded under Title V, we will lose an invaluable opportunity to learn how we can effectively help young people avoid sexual activity—a risk behavior at least as detrimental to their health as the use of alcohol, drugs, and tobacco. And there will be no going back. If we damage the integrity of Title V the opportunity to fully explore this public health option will be lost. This is not about politics or ideology. This is about medicine, science, and data. All of which tell us the old approaches aren't working, not when millions of adolescents are contracting sexually transmitted diseases. We owe it to our young people to fully explore and evaluate the abstinence education approach, and that means continuing the Title V program as it is currently designed and being implemented.

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APPENDIX A: LIST OF SEXUALLY TRANSMITTED DISEASES

1. Gonorrhea; 2. Chlamydia; 3. Lymphogranuloma venereum (caused by certain strains of Chlamydia trachomatis); 4. Syphilis; 5. Chancroid; 6. Donovanosis (Granuloma inguinale); 7. Ureaplasma urealyticum; 8. Human Immunodeficiency Virus (HIV) Types I and II; 9. Shigellosis*; 10. Salmonellosis*; 11. Herpes Simplex Virus Types I and II; 12. Cytomegalovirus*; 13. Human Papillomavirus (approximately 30 sexually transmitted strains); 14. Molluscum contagiosum; 15. Hepatitis A; 16. Hepatitis B; 17. Hepatitis C*; 18. Hepatitis D*; 19. Body or pubic lice; 20. Trichomoniasis; 21. Scabies*; 22. Giardiasis*; 23. Amoebiasis*; 24. Bacterial vaginosis*; and 25. Human Herpes Virus type VIII;

* Sexual transmission occurs but is not the primary mode of transmission.

Mr. BILIRAKIS. Thank you very much, Doctor.
Dr. Kaplan.

STATEMENT OF DAVID W. KAPLAN

Mr. KAPLAN. Mr. Chairman, thank you very much for inviting me to testify before the subcommittee today on the important topic of sex education for our Nation's youth as you consider reauthorizing the abstinence only provisions of the 1996 law and formally known as welfare reform.

I am Chief of Adolescent Medicine and Professor of Pediatrics in the Department of Pediatrics at the University of Colorado School of Medicine and head of Adolescent Medicine at the Children's Hospital in Denver. As a physician who sees the realities of adolescent life on a daily basis, the struggles with emerging sexuality, the impact of peer pressure and the media, the effort to make responsible decisions and the consequences of poor choices, I wish to appeal to the subcommittee and indeed to the Congress as a whole to be realistic and responsible when it comes to sex education and to provide young people with all the information they need to protect their health and lives in the era of AIDS.

Do not make this an either/or issue because it's not. Young people need information about abstinence and they need information about contraception. They need information about abstinence because, as the American Academy of Pediatrics policy statement on adolescent HIV prevention states, "it is the surest way to prevent STDs including HIV infection and pregnancy."

The Academy policy statement goes on to say "although abstinence is the safest method of avoiding sexual exposure to HIV, it is impossible to predict which adolescents will remain abstinent. Therefore, education about safer sexual practices including the use

of condoms and other barrier methods needs to be provided to adolescents in order to protect them."

More than half of all the teens ages 15 to 19 in this country have had sex. That figure is nearly 70 percent for 18-year-olds. Whether you are a pediatrician or a policymaker, a parent or a teacher, this reality confronts us. We must stop politicizing the issue and acknowledge the need for teens to learn how to protect themselves from unintended pregnancy and STDs. Parents themselves are far more pragmatic and realistic than conventional wisdom would have us believe. The Kaiser Family Foundation released a major survey of parents, their teens, sex education teachers and principals and in that survey 85 percent of parents said how to use condoms and other forms of birth control should be covered as well as how to talk about their use with partners.

Young people themselves share similar views and say that there should be more, not less, information provided in sex education classes. Young people say there should be more information on how to use and where to get birth control. They also say they need more information on how to talk with the partner about birth control and sexually transmitted diseases.

I'm a physician. My testimony is based both on my experience in providing health care to teenagers over the last 30 years and scientific evidence. Neither the evidence justifies nor my experience supports further funding of abstinence only programs. In 2001, the National Campaign to Prevent Teenage Pregnancy found no credible studies of abstinence only education showing any significant impact on participants' initiation of or frequency of sex and contrary to the governing myth underpinning abstinence only education comprehensive sex education actually delays the onset of sex and reduces its frequency and increases contraceptive use. That's why comprehensive sex education, not abstinence only is worth funding.

Again, the American Academy of Pediatrics reached a similar conclusion on censoring information and denying access to contraception and I quote, "there is no evidence that refusal to provide contraception to adolescents results in abstinence or postponement of sexual activity. In fact, if adolescents perceive obstacles to obtaining contraception and condoms, they are more likely to have negative outcomes to sexual activity. In addition, no evidence exists that the provision of information to adolescents about contraception results in increased rates of sexual activity, earlier age of first intercourse or greater number of partners.

"Two school-based controlled studies have demonstrated a delay on the onset of sexual intercourse in the intervention group that used a comprehensive approach that included a discussion of contraception. Availability of contraception is not causally related to sexual experimentation."

Simply put, informing young people about contraception does not cause them to have sex. The basic foundation of sound public health policy is education.

There is a clear consensus among experts that abstinence only education that censors information about contraception does not constitute sound public health policy. Indeed, I cannot think of any

other issue which is so strongly endorsed by the leading health and medical organizations, yet remains held hostage to politics.

In 2001, the Surgeon General recommended giving information on both abstinence and contraception. The National Academy of Sciences Institute of Medicine criticizes abstinence only education and supports comprehensive sex and HIV education programs which it says can reduce high risk sexual behaviors among adolescents.

The National Institute of Health concluded "abstinence only programs cannot be justified in face of the effective programs given effect that we face an international emergency on HIV."

Mr. BILIRAKIS. Please summarize, Doctor.

Mr. KAPLAN. In summary, I would suggest a few key principles. First of all, do no harm. Provide medically accurate information about abstinence and contraception. Second, teachers should not be censored from answering young people's questions about their health. Third, we need to follow research, what really works, and last, we need to be realistic and provide young people with all the information they need to protect their lives and health in an era of AIDs.

Thanks very much.

[The prepared statement of David W. Kaplan follows:]

PREPARED STATEMENT OF DAVID KAPLAN, CHIEF OF ADOLESCENT MEDICINE, DEPARTMENT OF PEDIATRICS, UNIVERSITY OF COLORADO SCHOOL OF MEDICINE

Thank you very much for inviting me to testify before the subcommittee today on the important topic of sex education for our nation's youth, as you consider reauthorizing the abstinence-only provisions of the 1996 law informally known as "welfare reform." I am Chief of Adolescent Medicine and Professor of Pediatrics in the Department of Pediatrics, at the University of Colorado School of Medicine, and head of adolescent medicine at the Children's Hospital in Denver. I am also the Chairman of the Committee on Adolescence at the American Academy of Pediatrics.

As a physician who sees the realities of adolescent life on a daily basis—the struggle with emerging sexuality, the impact of peer pressure and the media, the effort to make responsible decisions and the consequences of poor choices' I wish to appeal to the subcommittee—and, indeed to the congress as a whole—to be realistic and responsible when it comes to sex education and to provide young people with all the information they need to protect their health and lives in the era of AIDS.

Do not make this an either/or issue—because it is not. Young people need information about abstinence and contraception. They need information about abstinence because, as the american academy of pediatrics policy statement on adolescent HIV prevention states, "it is the surest way to prevent stds, including HIV infection, and pregnancy."[1]

The academy policy statements go on to say: "although abstinence . . . is the safest method of avoiding sexual exposure to HIV, it is impossible to predict which adolescents will remain abstinent. Therefore, education about safer sexual practices, including latex condom use, and other barrier methods should be provided so adolescents might opt to stop or alter their sexual behavior."[2]

More than half of all teens aged 15-19 in this country have had sex. That figure is nearly 70% for 18 year-olds.[3] Whether you are a pediatrician or a policymaker, a parent or a teacher, this reality confronts us. We must stop politicizing the issue and acknowledge the need for teens to learn how to protect themselves from unintended pregnancy and STDs.

Parents themselves are far more pragmatic and realistic than conventional wisdom would have us believe. The Kaiser Family Foundation released a major survey

[1] Committee on Adolescence, American Academy of Pediatrics (AAP), *Condom Use By Adolescents,* 107(6) Pediatrics 1463, 1467 (June 2001).

[2] Committees on Pediatric AIDS and Adolescence, AAP, *Adolescents and Human Immunodeficiency Virus Infection: The Role of the Pediatrician in Prevention and Intervention,* 107(1) Pediatrics 188-190 (Jan. 2001).

[3] The Alan Guttmacher Institute (AGI), *Teen Sex and Pregnancy,* Facts in Brief (1999).

of parents, their teens, sex education teachers, and principals. In that survey, 85% of parents said how to use condoms and other forms of birth control should be covered, as well as how to talk about their use with partners (88%).[4]

Young people themselves share similar views, and say there should be more, not less, information provided in sex education classes. Young people say there should be more information on how to use and where to get birth control; they also say they need more information on how to talk with a partner about birth control and STDs.[5]

I am a physician. My testimony is based both on my experience providing health care to teenagers over the last 30 years and the scientific evidence. Neither the evidence justifies nor my experience supports further funding of abstinence-only programs. In 2001, the national campaign to prevent teen pregnancy found no credible studies of abstinence-only education showing any significant impact on participants' initiation of or frequency of sex. And contrary to the governing myth underpinning abstinence-only education, comprehensive sex education actually delays the onset of sex, reduces its frequency and increases contraceptive use.[6] That's why comprehensive sex education—not abstinence-only—is worth funding.

Again, the american academy of pediatrics reached a similar conclusion on censoring information and denying access to contraception:

"There is no evidence that refusal to provide contraception to an adolescent results in abstinence or postponement of sexual activity. In fact, if adolescents perceive obstacles to obtaining contraception and condoms, they are more likely to have negative outcomes to sexual activity. In addition, no evidence exists that provision of information to adolescents about contraception results in increased rates of sexual activity, earlier age of first intercourse, or a greater number of partners. Two school-based controlled studies that demonstrated a delay of onset of sexual intercourse in the intervention group used a comprehensive approach that included a discussion of contraception. Availability of contraception is not causally related to sexual experimentation." [7]

Simply put, informing young people about contraception does not cause them to have sex. The basic foundation of sound public health policy is education.

There is a clear consensus among the experts that abstinence-only education that censors information about contraception does not constitute sound public health policy. Indeed, I cannot think of any other issue which is so strongly endorsed by the leading health and medical organizations, yet remains hostage to politics.

- In 2001, the surgeon general recommended giving information on both abstinence and contraception.[8]
- The National Academy of Sciences' Institute of Medicine criticizes abstinence-only education and supports comprehensive sex and hiv/aids education programs, which, it says, can reduce high-risk sexual behaviors among adolescents.[9]
- The National Institutes of Health concluded: "abstinence-only programs cannot be justified in the face of effective programs and given the fact that we face an international emergency in the AIDS epidemic." [10]
- The American Academy of Pediatrics recommended last year that "all adolescents should be counseled about the correct and consistent use of latex condoms to reduce risk of infection." [11]
- The American Medical Association urges schools to implement comprehensive sex education programs that include information about contraceptives.[12]

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[4] News Release, Kaiser Family Foundation (KFF), National Study on Sex Education Reveals Gaps Between What Parents Want and Schools Teach (Sept. 22, 2000).

[5] *Id.*

[6] Douglas Kirby, *The National Campaign to Prevent Teen Pregnancy, Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy* (2001), at 88, 95.

[7] Committee on Adolescence, AAP, *Contraception and Adolescents,* 104(5) Pediatrics 1161 (Nov. 1999).

[8] *The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior* (July 9, 2001), at http://www.surgeongeneral.gov/library/sexualhealth/call.htm.

[9] Committee on HIV Prevention Strategies in the United States, Institute of Medicine, No Time to Lose: Getting More from HIV Prevention 118-20 (National Academy Press 2001).

[10] National Institutes of Health, *Interventions to Prevent HIV Risk Behaviors,* NIH Consensus Statement (Feb. 11-13, 1997), at 16.

[11] AAP, *supra* note 2.

[12] Council on Scientific Affairs, American Medical Association, Report 7 of the Council on Scientific Affairs (1-99): Sexuality Education, Abstinence, and Distribution of Condoms in Schools, at http://www.ama-assn.org/ama/pub/article/2036-2376.html (last visited Mar. 4, 2002).

- The American College of Obstetricians and Gynecologists supports sex education programs that include information about contraception.[13]
- And the American Public Health Association urges that comprehensive sex education be included as an integral part of all school systems' curricula.[14]

The Office of the Surgeon General. The Institute of Medicine. The NIH. The American Academy of Pediatrics. The AMA. ACOG. APHA. Those are the professionals, the most respected leadership in our country. Unanimously, they take the same, evidence-based approach I urge congress to adopt. Yet, in programs funded with abstinence-only dollars, teachers can't even answer students' questions about prohibited topics—despite experts' recommendations.

Information is a tool, not an opponent, of responsible, healthy decision-making. Our young people are not all the hormone-driven stereotypes we see portrayed so often in our culture. They are capable of making good choices. Depriving them of medically accurate information will not protect them. It will only make them more vulnerable.

Mr. Chairman, our nation's youth face a reproductive health crisis: despite some encouraging signs that adolescent pregnancy rates are declining[15], teens still confront the twin epidemics of teen pregnancy (numbering almost 900,000 a year[16]) and HIV, as well as other sexually transmitted diseases. Every day in America 10,000 young people contract a sexually transmitted disease, 2400 become pregnant, and tragically, 55 contract HIV.[17] I know in my heart that we can do a better job for our youth.

In closing, I would suggest that we follow a few key principles:

- Do no harm. Provide medically accurate information about abstinence and contraception.
- Teachers must not be censored from answering young people's questions about their health.
- Follow the research on what really works.
- Be realistic. Provide young people with all the information they need to protect their health and lives in the era of aids.

Thank you very much.

Mr. BILIRAKIS. Thank you very much, sir.

Ms. Mann.

STATEMENT OF CINDY MANN

Ms. MANN. Thank you, Mr. Chairman, and members of the committee for the opportunity to testify about health care coverage for families leaving welfare and specifically the Transitional Medical Assistance program.

Let me start with what I think is a sobering fact and that is if you are a parent, caring for a child, and you are poor, that is your income is below poverty, you are more likely to be uninsured if you have a job, than if you don't have a job. Poor parents who work are—43 percent of poor parents who work don't have health insurance coverage. This anomaly occurs because poor and near poor parents are caught between two systems of coverage. The first system, I think which most of us are most familiar with is the employer-based health care system. Most of us get our health insurance coverage from our employers, but that's not true with low

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[13] American College of Obstetricians & Gynecologists (ACOG) Statement of Policy, Statement on Sexuality Education (July 1996); ACOG Statement of Policy, The Limitations of Abstinence-Only Sexuality Education (May 1998).

[14] American Public Health Association, Policy Statement 9309: Sexuality Education (Jan. 1, 1993).

[15] Ventura et al., *Declines in Teenage Birth Rates,* 1991-98: Update of National and State Trends, National Vital Statistics Report (Centers for Disease Control & Prevention) (Oct. 25, 1999), at 2.

[16] AGI, *Teenage Pregnancy: Overall Trends and State-by-State Information* (Apr. 1999), table 3.

[17] Pregnancy and STD statistics are for teens aged 15-19; HIV statistics are for young people aged 13-24. *Id.*; KFF & American Social Health Association, Sexually Transmitted Diseases in America: How Many Cases and at What Cost? 4, 8 (1998); Office of National AIDS Policy, The White House, *Youth and HIV/AIDS: A New American Agenda* (Sept. 2000), at v.

wage workers. If you have low wages, you're much less likely to get coverage through your job. A study in 1988 looking at people with earnings of about $7 an hour or less showed that only 50 percent of them had employer-based coverage either through their own employer or through their spouse's employer. Forty percent weren't offered coverage at all, and 10 percent declined that coverage largely because of their costs.

The second system that poor parents are caught between is publicly funded coverage. Medicaid and the States Children's Health Insurance Program now offered coverage to most of the children in low income working households, however, the parents in those households are largely left out of publicly financed coverage. Medicaid eligibility for parents is no longer tied to welfare. Delinking Medicaid and welfare eligibility was part of the welfare law that was enacted in 1996. However, most States set their eligibility levels for parents in Medicaid at income levels that are about the same levels as welfare. If you earn about the average wage that people earn when they leave welfare for work, about $1300 a month, which is about the poverty line for a family of three, you are ineligible for Medicaid in 39 States. That's where TMA comes in and the Chairman aptly described the purpose of TMA. It provides time-limited Medicaid coverage to those parents who already have Medicaid coverage and who then get a job and would lose their on-going regular Medicaid coverage because of their earnings. They don't get employer-based coverage. They're no longer eligible for regular Medicaid. TMA provides them an extension of coverage. It doesn't last forever. It's limited to 12 months and some people get it for less than 12 months, but it does assure that a parent can take the job and not immediately at least lost their Medicaid coverage when they join the workforce.

It's a program that's enjoyed broad bipartisan support for almost 20 years. It was first created actually in 1984, amended and expanded in 1998 and revisited and extended again in 1996 at the Welfare Law and extended again in the year 2000.

While there seems to be very broad consensus in this committee and beyond that TMA ought to be continued, there has been some concern about low participation rates in the TMA program. In the past several years there's been a considerable amount of attention paid as to why Medicaid rolls have declined at the same welfare rolls have declined, even though the two programs have become delinked. There were many reasons for some of the problems that were experienced, particularly having to do with State and local implementation of the delinking provisions and some slowness at the State and local level to change computer systems to ensure that when people left the welfare system, they were properly continued on Medicaid, generally, and on TMA if that was the category of Medicaid that they qualified for. Other problems arose because families didn't always know they were eligible for TMA.

Some of these problems have been addressed and Medicaid enrollment is beginning to rebound in a number of States. However, other problems have come to surface that have interfered with TMA participation. Let me mention a few steps that can be remedied only with legislative changes.

First, TMA is limited to those people who have been on Medicaid for at least 3 out of 6 months prior to getting a job. That seems to conflict with State efforts to encourage quick attachment to the labor market. Let me give you an example. If you are a family, you're on welfare in January and Medicaid is starting in January, you get a job in February that doesn't offer health insurance coverage and you're no longer eligible for Medicaid because of your wages, you would not be able to qualify for TMA under Federal rules because you will not have met that 3 out of 6 months requirement.

Second, TMA is limited to 12 months, as we've noted. Some States would like to extent TMA beyond that period of time, but they don't have the statutory discretion to do that.

And third, I'd like to mention some very prescriptive reporting requirements that are built into the Federal law. States must send families forms and families must fill out forms in the 4th, 7th and 10th month of this limited 12-month period of coverage. It's really the only area in the Medicaid statute that I can think of where the reporting requirements are laid out in this kind of way. Generally, States have the responsibility to make sure that people who are in the Medicaid program are eligible, but in the area of TMA, the statute is very prescriptive and tells States exactly how they need to proceed. These reporting requirements have been administrative barriers for States and they have caused eligible families to lose coverage.

Let me close by noting how important health care coverage is to the population that's targeted by TMA. Low-income parents tend to have greater health care problems than other people and those health care problems, as members have noted, will interfere with their ability to care for their children and to support their families through employment. Health coverage doesn't guarantee good health, but it certainly provides access to care that can bring a measurable difference in the lives of poor families.

When the welfare reform was debated in 1996, there was nearly universal agreement that health care coverage was a critical part of the support system to help struggling families stay afloat with limited wages. TMA is not the solution to the coverage problems faced by poor families, but it is certainly a very critical component of our far from perfect system.

Mr. BILIRAKIS. Please summarize, Ms. Mann.

Ms. MANN. Without TMA, there can be little doubt that more poor working parents will, in fact, join the ranks of the uninsured. I'll close there.

[The prepared statement of Cindy Mann follows:]

PREPARED STATEMENT OF CINDY MANN, SENIOR FELLOW, KAISER COMMISSION ON MEDICAID AND THE UNINSURED

Thank you for the opportunity to offer testimony on Transitional Medical Assistance.

I am Cindy Mann, Senior Fellow with the Kaiser Commission on Medicaid and the Uninsured. The national nonpartisan Commission services as a policy institute and forum for analyzing health care coverage and access for low-income populations and assessing options for reform. Before joining the Commission, I served as the Director of the Family and Children's Health Program Group at the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) over-

seeing the administration of Medicaid for families and children, including Transitional Medical Assistance.

Low-income people (those with incomes below 200% of the federal poverty line, or $30,040 for a family of three), including parents who have left welfare and are now employed, have a much higher risk than others of being uninsured. A third of low-income parents, including 40 percent of parents with incomes below poverty, lack health insurance coverage. (The poverty level is $15,020 for a family of three.) Figure 1. Ironically, poor parents are more likely to be uninsured if they are employed than if they are not employed (43% uninsured v. 31% uninsured) because low-wage workers often do not have access to employer-based coverage and, in most states, Medicaid eligibility standards for parents are so low that even parents with very low wages are "over income" and cannot qualify for ongoing Medicaid coverage.

Transitional Medical Assistance (TMA) is one policy that helps address this troubling dynamic. TMA offers critical support to many of the most vulnerable families in this nation. It provides temporary health care coverage to families with low wages, primarily those who have left welfare to take a job. TMA covers children and their parents, but it is particularly important for low-income working parents for whom TMA is often their only source of coverage. If TMA lapses at the end of this fiscal year, poor and near-poor parents will become uninsured, with adverse effects for their health, their ability to care for their children, and their capacity to retain employment and support their families. On the other hand, if TMA is extended and improved, even more low-income working parents will have a guarantee of coverage at least for a limited period of time.

TMA has been supported and expanded over the years

TMA is a common-sense "welfare-to-work" initiative that was created with strong bipartisan support years before the current era of welfare reform. It was first established in 1984 and was revised and expanded in 1988 as part of the Family Support Act of 1988. During this time, Medicaid eligibility for families with children was linked to welfare. In general, this meant that families that received welfare (Aid to Families with Dependent Children, or AFDC) were automatically enrolled in Medicaid and that when a family left welfare its Medicaid coverage would end. Congress recognized that parents leaving welfare for work are often not offered coverage at their workplace and was concerned that the loss of Medicaid coverage could discourage families from seeking jobs and make it difficult for them to retain employment. The 1987 Report of the House Energy and Commerce Committee accompanying the measure that broadened TMA noted that "(F)ormer AFDC families that work their way off welfare have the greatest need for health care coverage, because they are least able to pay for services out of pocket and because their health is more likely to be poor. Yet these are precisely the families that are among those most likely to be uninsured."[1] TMA assured that parents receiving welfare could take a job without losing Medicaid at least for a limited period of time.[2]

In 1996, when Congress drafted the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) to replace AFDC with the Temporary Assistance to Needy Families (TANF) block grant, it revisited Medicaid coverage rules, including TMA. Welfare reform underscored the important role Medicaid plays for low-income families, including those who may not be receiving welfare. PRWORA broke the historic link between Medicaid and welfare and created in its place a new Medicaid eligibility category for families with children. Under these new rules, families qualify for Medicaid based on their income, not based on their status as welfare recipients. PRWORA also extended TMA to 2001, demonstrating Congress' continued commitment to assuring that families would not immediately lose health care coverage if they left welfare because a parent in the family found employment. The TMA sunset date was extended for one more year in legislation enacted in 2000.[3]

Under current law, states must provide TMA to families who otherwise would become ineligible for ongoing Medicaid coverage under the new family coverage category ("section 1931") created by PRWORA.[4] TMA is available if the family was receiving Medicaid for three out of the prior six months and is losing regular Medicaid because of earnings or child support payments. If the receipt of child support triggers TMA coverage, the family is eligible for four months of coverage. If TMA is based on earnings, the family is eligible for six months of coverage, plus an additional six months if family income, less child care expenses, stays below 185 percent of the poverty level ($27,787 for a family of three) and the family complies with federal reporting requirements. Families with access to employer-based coverage can combine this coverage with Medicaid. TMA would cover some medical services not covered by the employer plan, and help pay premiums and cost sharing imposed by

the employer plan. Employer-based coverage is often not available to parents leaving welfare

While most Americans receive their health care coverage through employer-subsidized plans, low-wage workers are substantially less likely to have job-based coverage. In 1998, only half of the workers earnings less than $7 an hour (which is close to the average wage earned by those leaving welfare who are employed) were covered by plans offered either by their employers or their spouses' employer. Forty percent were not offered health insurance and an additional 10 percent declined an offer of coverage, largely as a result of costs. Figure 2. Even without considering deductibles and co-payments, the average cost of maintaining coverage offered through the work place is often well beyond the reach of parents leaving welfare. The average employee contribution for family coverage in 2001 would consume 11 percent of the average gross earnings reported by families leaving welfare for employment ($1,360 a month).[5] Individual coverage is less costly but still difficult for many families living below or close to the poverty level to afford, and premium costs are rising rapidly.

Other factors that typify the circumstances of many of the families leaving welfare also contribute to low rates of employer-based coverage among TANF leavers. Parents leaving welfare are often new employees both because they may be entering the labor market for the first time and because they change jobs often due to the dynamics of the low-wage labor market and the challenges of maintaining child care and reliable transportation. New employees are often not offered employer-based coverage even in firms that offer longer-term employees coverage. In addition, women leaving welfare frequently find work at retail or service firms where employer-based coverage is less prevalent.

For all these reasons, only a small portion of families leaving welfare have employer-based coverage. The Urban Institute found that, in 1999, on average, only one out of five parents had employer-based coverage in the first year after leaving welfare. Employer-based coverage picked up substantially after one year, but still, even at a time when the economy was particularly strong, only a minority (44%) of parents had employer-based coverage more than one year after leaving welfare.[6]

For parents, regular Medicaid often does not fill the gap left by employer-based coverage

Medicaid and now the State Children's Health Insurance Program (SCHIP) fill in much of the gap in coverage for children left by relatively low rates of job-based coverage among low-income workers and their dependents. Under federal minimum eligibility standards, all states must provide Medicaid coverage to children under age six if their incomes are below 133 percent of the federal poverty line ($19,977 for a family of three). Older children must be covered if their income is below the poverty level. Options available to states to receiving federal matching funds to cover children at higher levels have prompted most states to expand coverage through Medicaid and SCHIP beyond these minimum levels. As of January 2002, every state covered children with incomes up to at least 140 percent of the poverty line, and all but 11 states covered children with incomes up to 200 percent of FPL. As a result, most (83%) low-income children are now eligible for Medicaid or SCHIP.[7] Many immigrant children are still left out of coverage, but for most other children the primary challenge is to improve participation rates in Medicaid and SCHIP.

The story is far different for the parents of these children. There is no uniform national minimum eligibility standard applicable to parents under Medicaid; the federal minimum standard varies by state pegged to the state's 1996 AFDC income standard. States have options to broaden their family coverage to reach more low-income working parents, but to date, only 18 states cover parents with incomes at 100 percent of the poverty level through regular Medicaid (or through a waiver). In seven states the income eligibility standard for a parent with earnings is below 33 percent of the poverty line ($4,957 for a family of three). Figure 3.

As a result of these low eligibility standards, in most states low-income working parents, including many of those leaving welfare, have too much income to qualify for regular Medicaid. The earnings of those who leave welfare and find jobs average $1,360 a month.[8] This is below the poverty level for a family of three, yet in 39 states a parent with two children earning this amount will be "over income" for regular Medicaid.[9] In the absence of TMA, most parents at these wage levels would not have any route to Medicaid coverage unless they are pregnant or disabled. Given limited access to employer-based coverage, parents moving into the labor market earning these wages would be at great risk of being uninsured if TMA were not available.

TMA implementation issues

While TMA has been a valuable source of coverage for millions of people in low-income working families, TMA has not always operated smoothly for either families or for states. Some problems have arisen as a result of implementation problems at the state and local level. In addition, some families do not take advantage of TMA because they are unaware of the coverage it offers. Families often close their Medicaid case when someone in the household finds employment, unaware that they may continue to be eligible for Medicaid. Many families wrongly assume that they have to be receiving welfare in order to qualify for Medicaid.[10]

Implementation problems were identified following the enactment of the federal welfare law in 1996. The welfare rolls plummeted, and, in many states, Medicaid enrollment dropped sharply as well even though most families leaving welfare should have been eligible for Medicaid at least for a temporary period of time.[11] Some of the decline occurred because state and local procedures and computer systems did not ensure that families who were leaving welfare were being properly evaluated for continuing Medicaid eligibility, including TMA. Studies have found that only one third to one half of the adults leaving welfare had Medicaid coverage following their TANF exit. According to an analysis by the Urban Institute relying on 1999 data, half of the women leaving welfare had Medicaid coverage during the year after leaving TANF. More than one-third (37%) percent were uninsured.[12] Figure 4. TANF "leavers" studies funded by the Department of Health and Human Services had similar findings.[13]

As a result of the unanticipated drop in Medicaid enrollment following welfare reform, many states began to focus in on the problem and make corrections, sometimes as a result of litigation or the threat of litigation.[14] In 1999 through 2000, the Centers for Medicare and Medicaid Services (formerly HCFA) visited each of the 50 states and issued reports on state and local policies and procedures, and in April of 2000, CMS instructed all states to take steps to address any problems that might continue to exist and to restore coverage to children and parents who had been terminated from coverage improperly.[15]

Partly as a result of these state and federal efforts, Medicaid enrollment began to rebound in 1998, although enrollment trends varied significantly across states. Indiana's experience is instructive. The state identified implementation problems and outreach needs and took a number of steps to improve policies and procedures so that families moving in and out of the welfare system as well as those who did not apply for welfare did not lose out on Medicaid coverage. After three years of enrollment declines, Indiana saw its family caseload in Medicaid rise by 40 percent between May 1998 and April 2000. TMA enrollment quadrupled during this period.[16] Indiana's experience shows that proper implementation coupled with aggressive outreach can make a substantial difference in the extent to which Medicaid generally and TMA specifically live up to their potential for covering low-income working families.

TMA design issues

There appears to be broad consensus that TMA is an important component of the Medicaid program and state and federal welfare-to-work initiatives. Some changes in the federal design of TMA could, however, boost participation. Some of these changes have been proposed in pending legislation. [17]

- Currently, TMA is available only to families that have been enrolled in regular Medicaid for at least three out of the last six months. Some states have noted that this requirement is not consistent with their welfare program's "work first" approach, which stresses a quick attachment to the labor market. If a family begins receiving welfare and Medicaid in January and the parent finds a job in February with wages that would make the family ineligible for regular Medicaid, that family would not be eligible for TMA because it would not have satisfied the "three out of six months" requirement.
- The federal law includes prescriptive TMA reporting requirements. In order to retain eligibility throughout the full 12-month period, families must submit written reports of their earnings and child care expenses in the 4th, 7th, and 10th months. These reporting requirements create administrative burdens for states and can cause coverage problems for families. The GAO has recommended that Congress consider allowing states flexibility to change or eliminate these reporting requirements.[18]
- Some states have been interested in extending TMA beyond the 12 months allowed under the law. A few states have waivers extending TMA, but these waivers are generally no longer available due to budget neutrality rules.[19] A legislative change would be necessary to allow states the option to provide TMA for longer periods of time.

Health Coverage Makes a Difference

With or without improvements in the way TMA operates, there is nearly universal agreement that TMA plays an important role promoting welfare-to-work efforts and providing health care coverage to some of the most vulnerable families. Health care coverage alone does not guarantee quality health care, but coverage makes it much more likely that people will get the health care they need. A recent study showed that low-income adults are almost three times more likely to have an unmet medical need if they are uninsured.[20] Those with Medicaid coverage do not report these same levels of unmet needs. For example, a study found that low-income women are 2.5 times more likely to report unmet or delayed health care needs than are low-income women with either Medicaid or private coverage.[21] Figure 5.

As the Congress recognized when it expanded TMA in the Family Support Act of 1988, parents relying on welfare and those leaving welfare for work are often in poor health. Poor health status is generally correlated with low incomes.[22] Health-related problems take their toll on poor women's ability to care for their families and to work and retain employment. The National Governors Association has identified health-related problems as a key barrier to work and a challenge to state welfare-to-work initiatives.[23] Recent reports have highlighted the importance of quality coverage as a means of decreasing absenteeism and increasing productivity at work.[24] While coverage does not assure good health, it affords individuals access to health care, which can help them manage and address health problems and better care for their children and participate in the work force.

TMA is a critical component of the labyrinth of mechanisms by which some of the people who do not have access to employer-based coverage can obtain health care coverage. It has a limited reach both because it is a targeted program and because it provides time-limited coverage. Even with TMA, four out of ten poor parents are uninsured, and with a souring economy, rising health costs, and state budget cutbacks, the number of low-income people who lack health insurance coverage is expecting to rise. By extending TMA and perhaps improving how it works, Congress will be assuring that some of America's hardest working families do not join the ranks of the uninsured.

References

[1] H.R. Rep. No. 159, 100th Congress, 1st Sess., Part 3, at 12.

[2] TMA was also extended to families who might otherwise lose Medicaid due to child support income so that successful efforts to increase child support payments from absent parents did not result in the immediate loss of health care coverage.

[3] Congress extended the sunset date to September 30, 2002 in P.L. 106-554, section 707(a).

[4] Technically this means that a family does not have to be receiving welfare in order to qualify for TMA, since welfare receipt is no longer an eligibility requirement for Medicaid. However, as explained below, in most states the income standards for the family coverage category are so low that in those states TMA still largely functions as a welfare-to-work initiative.

[5] Data on average premium costs for employees are from Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2001 Annual Survey,* 2001; data on average wages of parents leaving welfare are from P. Loprest, *How are Families That Left Welfare Doing? A Comparison of Early and Recent Welfare Leavers,* New Federalism Policy Brief, Urban Institute, April 2001.

[6] Urban Institute analysis of 1999 National Survey of America's Families.

[7] L.Dubay, J.Haley, G.Kenney, *Children's Eligibility for Medicaid and SCHIP: A View from 2000,* Urban Institute, January 2002. These figures take into account restrictions in Medicaid and CHIP based on immigration status. About eight percent of low-income children are not eligible for coverage based on federal Medicaid immigration-related eligibility restrictions.

[8] P. Loprest, *How are Families That Left Welfare Doing? A Comparison of Early and Recent Welfare Leavers,* New Federalism Policy Brief, Urban Institute, April 2001.

[9] KCMU analysis of K. Maloy et al, *Can Medicaid Work for Working Families,* George Washington University, and M.Broaddus et al, *Expanding Family Coverage: States' Medicaid Eligibility Policies for Working Families in the Year 2000,* Center on Budget and Policy Priorities. In some states, a parent receiving Medicaid who finds a job may be able to receive Medicaid at somewhat higher income levels for a limited period of time due to earning disregards that are available to persons already receiving Medicaid.

[10] M. Perry, Kannel, S., Valdez, R.B., Chang, C. *Medicaid and Children: Overcoming Barriers to Enrollment,* Kaiser Commission on Medicaid and the Uninsured, January 2000.

[11] GAO, *Medicaid Enrollment: Amid Declines, State Efforts to Ensure Coverage After Welfare Reform Vary,* GAO HEHS-99-163, September 1999.

[12] Urban Institute analysis of 1999 National Survey of America's Families, April 2002. These figures do not add up to 100 percent because some people have both private coverage and Medicaid.

[13] G. Acs, P. Loprest, T. Roberts, *Final Synthesis Report of Findings from ASPE "Leavers" Grants,* Urban Institute, December 2001, Chapter IV, http://aspe.hhs.gov/hsp/leavers99/synthesis02/index.htm.

[14] Efforts taken by Washington state and Pennsylvania and Maryland are described at http://www.hcfa.gov/medicaid/wrmdpawa.htm. See also, *Adjusting Computer Systems for the TANF*

De-link, prepared by C. Gerhardt, State of Maryland, Department of Health and Mental Hygiene, hcfa.gov/med/mmis/927mann.pdf.

[15] CMS, Letter to State Medicaid Directors, April 7, 2000; http://www.hcfa.gov/medicaid/letters/smd40700.htm.

[16] Statement of Kathleen Gifford, Assistant Secretary, Office of Medicaid Policy and Planning, Indiana Family and Social Services Administration, House Ways and Means Committee, Subcommittee on Human Resources on Health Coverage for Families Leaving Welfare, May 16, 2000.

[17] HR 2630, HR 2775, and S.1269.

[18] GAO, *Medicaid Enrollment: Amid Declines, State Efforts to Ensure Coverage After Welfare Reform Vary,* GAO HEHS-99-163, September 1999.

[19] According to CMS, 11 states had waivers to extend TMA beyond 12 months, but only 6 of these waivers are currently in effect and 3 will expire in 2002. In the past, states were able to show that these waivers would not add to federal costs because they would lower AFDC costs by preventing some families from having to fall back on welfare because they lacked health coverage while they were working. Now that AFDC has been replaced by the TANF block grant, a decline in the welfare caseload due to extended TMA would not reduce federal expenditures.

[20] B. Strunk, P. Cunningham, *Treading Water: American's Access to Needed Medical Care, 1997-2001*, Health Systems Change Tracking Report, Results from the Community Tracking Study, No. 1, March 2002.

[21] R. Almeida, L. Dubay, G.Ko, "Access to Care and Use of Health Services by Low-income Women", *Health Care Financing Review,* 2001; 22:27-47.

[22] See, for example, H. Mead, K. Witkowski, B.Gault, H. Hartmann, "The Influence of Income, Education and Work Status on Women's Well-being", *Womens Health Issues,* 2001; 11:160-172, comparing the health status of poor women with that of women with incomes above 200 percent of the poverty level. The study found that poor women were more than three times as likely as nonpoor women to report fair or poor health (34% v. 9%). The GAO has found that a significant portion of TANF recipients are disabled have poor mental and physical health, suffer from substance abuse and have experienced domestic violence. GAO, *Welfare Reform: Moving Hard-to-Employ Recipients Into the Workforce 2001,* GAO-01-368. Other studies have found that many current and former TANF recipients have mental health problems, including depression. Lennon, Blome, English, *Depression and Low-Income Women: Challenges for TANF and Welfare-to-Work Policies and Programs,* Research Forum on Children, Families and the New Federalism, National Centers for Children in Poverty, 200l.

[23] S. Callahan, *Understanding Health-Status Barriers that Hinder Transition from Welfare to Work,* National Governors Association, 1999.

[24] TC Buchmueller, *The Business Case for Employer-Provided Health Benefits: A Review of the Relevant Literature,* California Health Care Foundation, 2000.

Mr. BILIRAKIS. Thank you very much.

Dr. Scanlon.

STATEMENT OF WILLIAM J. SCANLON

Mr. SCANLON. Thank you very much, Mr. Chairman and members of the subcommittee. I'm pleased to be here today to talk about our work on the uninsured and the traditional Medicaid program as it relates to Transitional Medical Assistance that you're considering reauthorizing.

This additional year of Medicaid coverage can play a critical role in supporting individuals as they transition from welfare to work. As everyone agrees and as Ms. Mann indicated, having health insurance is important for all persons. Health insurance and the access to the services it affords may be particularly important for those who are coming off of welfare who may have more health problems than average. Access to health insurance and health care on a timely basis helps avoid the development of some problems and the exacerbation of others which may result in longer term impairments and costs. For example, the uninsured are much more likely to be hospitalized for avoidable conditions such as asthma and diabetes. The uninsured are much more likely to be diagnosed with cancer at a later stage where there's less of a positive prognosis for improvement.

While securing a job to leave welfare is a very positive first step, however, our work and the work of others on the uninsured and on the insurance markets makes it clear that these newly employed individuals may have significant difficulty obtaining adequate

health insurance. As you know, and as Ms. Mann indicated, we rely heavily on the employer-based health insurance system. Over two-thirds of non-elderly Americans get their health insurance through their employers, but at the same time it's true that 75 percent of the uninsured adults are employed. This is because not all employers offer insurance and not all workers that are offered insurance choose to purchase it. Especially vulnerable are individuals who work part-time, are employed in low wage jobs or who work in certain industries such as retail services. These are exactly the types of jobs that many former welfare recipients have.

Even when employers offer coverage, a significant number of individuals leaving welfare may not accept it. The cost may be simply too high as employees of some firms are asked to pay a significant share of premiums. Transitioning workers commonly have jobs that pay $7 or $8 per hour. Getting coverage on their own through the individual insurance market may be even more expensive or even potentially impossible. It will depend upon State laws whether these individuals are guaranteed access to insurance coverage or whether there is any limitation on premiums. We have found repeatedly in our work on the individual insurance market that persons with health problems can be denied coverage completely or charged considerably more than the standard premium, unless prohibited by State law.

In this context, Transitional Medical Assistance provides an important protection to families in their efforts to move from welfare to work. In our prior work on transitional Medicaid, we found wide differences across the States in the shares of persons eligible for the program that actually enrolled, and large shares of persons who, when enrolled, did not receive the full year of coverage authorized.

Several States have worked to facilitate beneficiaries' access through outreach, education and other efforts and have achieved participation rates of over 70 percent among families transitioning to the workforce. Interestingly, some of the outreach and education is directed at State and county eligibility workers, to ensure that they properly assist potential eligibles to enroll. Other efforts target eligible individuals and employers to increase awareness of the benefit.

A key factor though in why many families did not receive their full program benefits was that they did not report their incomes as required, that is, at the 4th, 7th and 10th months of their enrollment, the requirements that Ms. Mann had indicated. In fact, State officials told us that families typically receive coverage for only 6 months and that was generally the result of the required income reports not being submitted, not because the families' incomes had become too high to be eligible for the program. The reporting requirements are aimed at assuring the program benefits go to persons who are genuinely eligible. This is an important objective. Nevertheless, that goal needs to be weighed against the cost of achieving it.

Administrative costs submitting and reviewing required documentation for beneficiaries and State workers are one element to consider. Also, very important is whether the primary objective of the program providing coverage to eligible beneficiaries is being

compromised. Some States have secured waivers of the reporting requirements so that their eligibles can get their full year of coverage. This committee has previously endorsed giving all States that flexibility to alter the reporting requirements and providing this flexibility for States to provide a full year of transitional Medicaid coverage would likely improve access to the benefits considerably. And it would put transitional Medicaid on a par with some other coverage options in the Medicaid program.

Thank you very much, Mr. Chairman. This concludes my statement and I will be happy to answer any questions.

[The prepared statement of William J. Scanlon follows:]

PREPARED STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH CARE ISSUES, UNITED STATES GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee: I am pleased to be here today as you consider the role of Medicaid in helping families' transition from welfare to the workforce. Since 1988, the Medicaid program has offered transitional Medicaid assistance, which provides certain families who are losing Medicaid as a result of employment or increased income up to one year of additional Medicaid health insurance coverage. Transitional Medicaid assistance was originally enacted for a 10-year period, and has twice been extended to help provide continued health insurance coverage to families moving into employment.[1]

The enactment of federal welfare reform in August 1996 significantly changed federal welfare policy for low-income families with children in several ways, including establishing a 5-year lifetime limit on cash assistance.[2] The welfare reform law also extended transitional Medicaid assistance through 2001, thus continuing an important link to health insurance coverage for individuals as their economic circumstances changed. States have implemented a variety of initiatives intended to help families move from cash assistance to the workforce, including some enhancements to transitional Medicaid. These initiatives have likely contributed to a drop in cash assistance caseloads of more than 50 percent from 1996 through mid-2001.[3]

Because the transitional Medicaid provision is due to expire in September 2002 and you are considering its extension, you asked us to provide information on the role this program plays in supporting transitions from welfare to work. Accordingly, my remarks today will focus on how

- transitional Medicaid assistance provides low-income working families an option to maintain health insurance coverage, and
- states have used transitional Medicaid to provide health insurance coverage to families.

My comments are based largely on our previously issued reports and testimony on Medicaid and welfare reform.[4]

In summary, transitional Medicaid assistance is a key protection offered to families at a critical juncture in their efforts to move from welfare to work. Employment in low-wage or part-time positions—which is common for these newly working individuals—frequently does not provide adequate access to affordable health insurance, whether through employer-sponsored or individually purchased health insurance, thus making transitional Medicaid coverage an important option. Our earlier work showed that, for 21 states we reviewed, the implementation of transitional Medicaid assistance varied across the states and that certain state practices had enhanced beneficiaries' ability to retain Medicaid coverage. For example, some states reported

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[1] The Family Support Act of 1988 created the transitional Medicaid assistance program as § 1925 of the Social Security Act, and was scheduled to expire on September 30, 1998. *See* Pub. L. No. 100-485, § 303(a), 102 Stat. 2343, 2385, and 2391. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 extended states' obligation to provide transitional Medicaid assistance through 2001. *See* Pub. L. No. 104-193, § 114(c), 110 Stat. 2105, 2180. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, extended the sunset provision to September 30, 2002. *See* Pub. L. No. 106-554, Appendix F, § 707, 114-2763A-463, 114-2763A-577.

[2] *See* The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 103, 110 Stat. 2105, 2137.

[3] *See* U.S. General Accounting Office, *Welfare Reform: States Provide TANF-Funded Work Support Services to Many Low-Income Families Who Do Not Receive Cash Assistance,* GAO-02-615T (Washington, D.C.: April 10, 2002).

[4] See GAO related products at the end of this statement.

increasing training for state eligibility determination workers to better inform beneficiaries of this entitlement and how to access it. We also found, however, that many families did not receive their full transitional Medicaid assistance benefits because they failed to report their income three times, as required, throughout the 12-month period of coverage. Amending the Medicaid statute to provide states with additional flexibility to ease income-reporting requirements for the coverage period of transitional Medicaid assistance, as has been done for other aspects of the Medicaid program, could further facilitate uninterrupted health insurance coverage for families moving from cash assistance to the workforce.[5]

BACKGROUND

Transitional Medicaid assistance offers families moving from cash assistance to employment the opportunity to maintain health insurance coverage under Medicaid, a joint federal-state health insurance program. Medicaid spent about $216 billion in fiscal year 2001 on coverage for certain low-income individuals.[6] Transitional Medicaid assistance provides certain families losing Medicaid as a result of employment or increased income with up to one year of Medicaid coverage.[7] Families moving from cash assistance to work are entitled to an initial 6 months of Medicaid coverage without regard to the amount of their earned income, and 6 additional months of coverage if family earnings, minus child care costs, do not exceed 185 percent of the federal poverty level.[8] To qualify for either 6-month period, a family must have received Medicaid in 3 of the 6 months immediately before becoming ineligible as a result of increased income.[9]

When federal welfare reform was enacted in 1996, states implemented a variety of initiatives intended to help families move from welfare to the workforce. Welfare reform provided states additional flexibility in helping cash assistance recipients to both find work and achieve family independence. As a result, states have expanded and intensified their provision of work support services such as those for job search, job placement, and job readiness.[10] Many individuals in this population had low skills and faced a number of barriers to maintaining work and independence. For example, our work has shown that factors such as limited English proficiency, poor health, and the presence of a disability were some of the factors that affected the extent to which former cash assistance recipients were able to find and keep employment.[11]

Maintaining health insurance coverage is important to persons entering the workforce because there are important adverse health and financial consequences to living without health insurance. The availability of health insurance enhances access to preventive, diagnostic, and treatment services as well as provides financial security against potential catastrophic costs associated with medical care. Research has demonstrated that uninsured individuals are less likely than individuals with insurance to have a usual source of care, are more likely to have difficulty in accessing health care, and generally have lower utilization rates for all major health care services. Uninsured individuals are more likely than those insured to forgo services such as periodic check-ups and preventive services, well-child visits, prescription drugs, dental care, and eyeglasses. As a result, individuals not covered by health

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[5] See U.S. General Accounting Office, *Medicaid Enrollment: Amid Declines, State Efforts to Ensure Coverage After Welfare Reform Vary,* GAO/HEHS-99-163 (Washington, D.C.: Sept. 10, 1999). In this report, we recommended that the Congress consider allowing states to lessen or eliminate requirements for beneficiary income reporting in transitional Medicaid assistance. We also recommended that the Administrator of the Health Care Financing Administration (HCFA) (1) determine the extent to which transitional Medicaid is reaching the eligible population and (2) provide states with guidance regarding best approaches for implementing this benefit. Since that time, HCFA, now the Centers for Medicare and Medicaid Services has acted on the second recommendation, but not the first.

[6] States administer Medicaid within broad federal guidelines that specify the categories of low-income individuals that states must cover and the categories that are optional. However, not all low-income individuals are eligible for Medicaid; for example, most childless adults are not eligible. In fiscal year 1999 (the most recent enrollment data available), Medicaid financed coverage for nearly 41 million individuals.

[7] Prior to welfare reform, some states received waiver authority under § 1115 of the Social Security Act to extend Medicaid benefits beyond the 12 months allotted in § 1925 of the Social Security Act. After August 22, 1996, this waiver became subject to a budget neutrality test, which meant that the cost of extending coverage had to be offset by transitional coverage.

[8] In 2002, the federal poverty level for a family of three was $15,020, or about $1,252 per month.

[9] GAO/HEHS-99-163, September 10, 1999.

[10] GAO-02-615T, April 10, 2002.

[11] See U.S. General Accounting Office, *Welfare Reform: Moving Hard-to-Employ Recipients Into the Workforce,* GAO-01-368, (Washington, D.C.: March 15, 2001).

insurance can require acute, costly medical attention for conditions that may be preventable or minimized with early detection and treatment.

TRANSITIONAL MEDICAID ASSISTANCE CAN FILL GAPS IN ACCESSIBILITY OF PRIVATE HEALTH INSURANCE FOR LOW-INCOME WORKERS

Limitations in private sources of coverage underscore the importance of transitional Medicaid assistance as an option for those moving from cash assistance to employment. Private health insurance is not accessible to or affordable for everyone. Although most working Americans and their families obtain health insurance through employers, many workers do not have coverage because their employers do not offer it or the coverage offered is limited or unaffordable. Lack of insurance is more common among certain types of workers, employers, and industries and may disproportionately represent individuals transitioning from cash assistance to work. For example, individuals who work part-time or are employed in low-wage jobs are less likely to have access to affordable employer-sponsored coverage. Furthermore, those who do not have employer-sponsored coverage may find alternative sources of coverage, such as the individual insurance market, expensive or altogether unavailable. Without continued access to Medicaid, some of these individuals, who are often in low-wage jobs, will have limited or no access to alternative coverage and could end up uninsured.

Private Sources of Health Insurance Are Not Universally Available And May Have Coverage Limitations

Employment-based coverage is the primary means for nonelderly Americans to obtain health insurance, and over two-thirds of nonelderly adults obtained their coverage through an employer in 2000. However, a significant number of workers do not have health insurance because either their employers do not offer it or they choose not to purchase it. In 2000, 30 million nonelderly adults were uninsured, even though 75 percent worked for some period during the year. (See fig. 1.)

Lack of insurance coverage is more common among certain types of workers, employers, and industries. Part-time employees and employees of small firms (fewer than 10 employees) are more likely to be uninsured than employees who work full-time or for a large company. Individuals working in certain industries are less likely to be offered health insurance. For example, in 1999, more than 30 percent of workers in the construction, agriculture, and natural resources (for example, mining, forestry, and fisheries) industries were uninsured, as were about 25 percent of workers in wholesale or retail trade. In contrast, 10 percent or less of workers in the finance, insurance, real estate, and public employment sectors were uninsured. These patterns may disproportionately affect individuals leaving cash assistance because they often work in low-wage jobs, part-time, or in industries such as retail that often do not provide health coverage.

Young adults, aged 18 to 24, are more likely than any other age group to be uninsured, largely because certain characteristics of their transition to the workforce—working part-time or for low wages, changing jobs frequently, and working for small employers—make them less likely to be eligible for employer-based coverage. Among those aged 18 to 24, 27 percent were uninsured and among those aged 25 to 34, 21 percent were uninsured in 2000. (See fig. 2.)

Even when employer-sponsored coverage is available, its costs may be prohibitive or its benefits very limited. Employer-sponsored health plans may not subsidize coverage for dependents, may restrict or exclude certain benefits, or may subject participants to out-of-pocket costs either through premium contributions or cost-sharing provisions that low-wage workers may find unaffordable. For example, a 2001 survey by Mercer/Foster Higgins found that, on average, large employers (500 or more employees) require employees enrolled in preferred provider organizations (PPO) to contribute $56 each month for employee-only coverage, or $191 each month for family coverage.[12] For lower-wage workers, such as individuals leaving cash assistance and entering the workforce, even coverage that is affordable for a worker may be too expensive for covering the rest of the family members.

Those without access to employer-sponsored coverage may look to the individual insurance market to obtain coverage, and in 2000, 5 percent of nonelderly Americans (or 12.6 million individuals) relied on individual health insurance as their only source of coverage. However, restrictions on who may qualify for coverage and the premium prices charged can have direct implications for consumers. For example, depending on their health status and demographic characteristics such as age, gen-

[12] Mercer/Foster Higgins, *National Survey of Employer-sponsored Health Plans 2001: Report on Survey Findings* (New York: William H. Mercer, 2001), p. 13. The Mercer/Foster Higgins survey is representative of all employers in the United States with at least 10 employees.

der, and geographic location, individuals in the majority of states may be denied coverage in the private insurance market or have only limited benefit coverage available to them. In addition, while all members of an employer-sponsored group health plan typically pay the same premium for employment-based insurance regardless of age or health status, in most states individual insurance premiums are higher for older or sicker individuals than for younger or healthier individuals, potentially making this option unaffordable.[13] For example, a recent study examined individual insurers' treatment of applicants with certain pre-existing health conditions, such as hay fever. The study of insurers in eight localities found that for applicants with hay fever, 8 percent would decline coverage, 87 percent would offer coverage with a premium increase, benefit limit, or both, and 5 percent would offer full coverage at the standard rate.[14] Cost differences are often exacerbated by the fact that individuals must absorb the entire cost of their health coverage, whereas employers usually pay for a substantial portion of their employees' coverage.

Transitional Medicaid Assistance Can Provide Continued Insurance Coverage

Because of limitations in the availability of private insurance—especially for low-paid, part-time workers and those in certain industry sectors that often characterize jobs available to individuals moving from cash assistance to work—transitional Medicaid assistance is an important option for health insurance coverage. Individuals with lower incomes have a much higher than average probability of being uninsured. (See fig. 3.) Typically, former welfare recipients entering the workforce work part-time or in low-wage jobs that are less likely to provide health coverage or only provide coverage at a prohibitive cost. For example, we noted in our 1999 report on states' experiences in implementing transitional Medicaid assistance that one state found that out of nearly l,600 former welfare recipients surveyed, 43 percent of the heads of households worked fewer than 32 hours per week and did not have health insurance, and 32 percent held low-wage jobs, such as in retail stores, hotels, restaurants, and health care establishments.

In addition, although some employers of former cash assistance recipients may not offer health insurance, numerous studies have shown that a significant number of these individuals have access to employer coverage but choose not to accept it. For example, a recent study showed that although about 50 percent of individuals transitioning from cash assistance to employment had access to employer coverage, only about one-third opted to participate in the employer-sponsored plan.[15] The relatively low "take-up" rate is due largely to the high costs of many employer health plans. Transitioning workers, who commonly earn between $7 and $8 an hour, may simply be unable to afford their share of the premium, since their annual earnings range from 73 percent to 111 percent of the federal poverty level. (See Table 1.)

Table 1: Hourly Wages as a Percentage of the Federal Poverty Level for a Family of Three, 2002

Hourly wage	Hours per week	Annual earnings	Salary as a percentage of the federal poverty level
$5.15 [1]	30	$8,034	53
	40	$10,712	71
$7.00	30	$10,920	73
	40	$14,560	97
$8.00	30	$12,480	83

[13] The Health Insurance Portability and Accountability Act of 1996 (HIPAA) guarantees some individuals leaving employer-sponsored group health plans access to continued coverage or to a product in the individual market. *See* 29 USC § 1181 (2000), 42 USC § 300gg (Supp. II 1996). Although individuals leaving public insurance programs, such as Medicaid, are not eligible for this HIPAA protection, they may obtain coverage in most states from high risk pools that provide coverage for applicants denied individual coverage due to health status. These policies tend to cost 25 to 100 percent more than rates charged to healthy individuals.

[14] Georgetown University Institute for Health Care Research and Policy and K.A. Thomas and Associates, *How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* (Washington D.C.: The Kaiser Family Foundation, 2001), http://www.kff.org (downloaded on August 14, 2001). The authors examined underwriting treatment of hypothetical applicants by 19 insurers in eight markets around the country.

[15] Gregory Acs, Pamela Loprest, and Tracy Roberts, *Final Synthesis Report of Findings from ASPE "Leavers" Grant* (Washington, D.C.: The Urban Institute, 2001). To conduct studies of families that had left welfare, the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services awarded competitive grants to select states and large counties in September 1998. This report synthesizes the findings from 15 of these studies.

Table 1: Hourly Wages as a Percentage of the Federal Poverty Level for a Family of Three, 2002—Continued

Hourly wage	Hours per week	Annual earnings	Salary as a percentage of the federal poverty level
	40	$16,640	111

[1] Represents the minimum wage, which was last increased on September 1, 1997.
Source: GAO analysis of salaries in relation to the 2002 federal poverty level of $15,020 for a family of 3.

STATES' EFFORTS ENCOURAGED USE OF TRANSITIONAL MEDICAID, BUT NOT ALL ELIGIBLE FAMILIES RECEIVED ASSISTANCE

While the Medicaid statute provides families moving from welfare to work with up to 12 months of transitional Medicaid coverage, we have reported that certain states had obtained waivers from HCFA to extend the length of coverage provided, and that the share of eligible families that actually received this entitlement varied significantly by state. States offered from 1 to 3 years of transitional Medicaid assistance in 1999. In the several states that were able to provide data on participation in transitional Medicaid assistance, we found that participation rates among newly working Medicaid beneficiaries ranged from 4 to 94 percent. Several states had made efforts to facilitate beneficiaries' participation in transitional Medicaid. For example, nine states reported developing outreach and education materials to inform families and eligibility determination workers about transitional Medicaid assistance. While such approaches helped make transitional Medicaid more available, beneficiaries' failure to report income as required often resulted in their losing eligibility after the first 6 months.

Length of Coverage and Program Participation Was Mixed Among States

States' implementation of transitional Medicaid coverage varied, resulting in differing lengths of time for which coverage was provided and differing rates of family participation. As of 1999, the most currently national data reported, 10 states—Arizona, Connecticut, Delaware, Nebraska, New Jersey, Rhode Island, South Carolina, Tennessee, Utah, and Vermont—provided over 1 year of coverage, while the remaining states provided 1 year of coverage. (See fig. 4.) In the several states that were able to provide such data, transitional Medicaid participation rates ranged from about 4 percent of the families moving from cash assistance in one state to 94 percent of such cases in another. However, low participation rates in transitional Medicaid assistance did not always indicate that families had lost Medicaid coverage altogether. For example, officials in the state with a 4 percent participation rate said that most families losing cash assistance were still enrolled in Medicaid through other eligibility categories for low-income families.

States' Initiatives Facilitated Beneficiary Use of Transitional Medicaid Assistance, But Not All Families Maintained Coverage

We found that several states had initiatives in place to facilitate beneficiaries' access to transitional Medicaid assistance. The following are examples of such initiatives.

- Nine states reported developing specific materials regarding transitional Medicaid assistance in easy-to-understand language for eligibility determination workers and beneficiaries.
- One state revised its computer systems so that eligible families leaving cash assistance due to employment were automatically transferred to transitional Medicaid assistance coverage. In addition, this state's eligibility workers randomly contacted families who were leaving cash assistance to determine their health insurance status and to ensure that they obtained the additional months of Medicaid coverage for which they were eligible. As a result of this state's efforts, about 70 percent of the families leaving cash assistance or Medicaid received transitional Medicaid coverage.
- Officials in three other states encouraged increased participation in transitional Medicaid assistance by contacting families with closed cash assistance cases to determine whether these families had obtained the additional months of Medicaid coverage if so entitled. One of these states, which also provided 24 months of transitional Medicaid assistance, reported that 77 percent of eligible families were receiving this benefit.

However, even with such successful enrollment efforts, many families did not receive the full transitional Medicaid assistance benefits because they failed to peri-

odically report their income as required. The Medicaid statute requires that beneficiaries report their income three times during the 12 months of transitional Medicaid assistance: once in the first 6-month period and twice in the second 6-month period. Failure to report income status in either of these 6-month periods results in termination of transitional Medicaid benefits.

In 1999, we reported that families' failure to periodically submit required income reports often resulted in their not receiving transitional Medicaid coverage for the full period of eligibility. For example, officials in three states we reviewed told us that families typically received only 6 months of transitional Medicaid, generally because they failed to submit the required income reports—and not because of a change in income that made them ineligible for transitional Medicaid. In contrast, the state that had a 94 percent participation rate for transitional Medicaid offered coverage for 24 months and had received HCFA approval to waive the periodic income reporting requirements. Overall, we found that states that waived income-reporting requirements reported higher participation rates than states that did not.

In implementing public programs such as Medicaid, difficult trade-offs often exist between ease of enrollment for eligible individuals and program integrity efforts to ensure that benefits are provided only to those who are eligible. The experience of some states in easing statutory periodic income reporting requirements proved successful in increasing participation for eligible beneficiaries. In view of concerns that beneficiary reporting requirements were limiting the use of the transitional Medicaid benefit, HCFA proposed legislation to eliminate beneficiary reporting requirements for the full period of eligibility (up to 1 year). To date, no action has been taken on this proposal. In our earlier report we recommended that the Congress may wish to consider allowing states to lessen or eliminate periodic income-reporting requirements for families receiving transitional Medicaid assistance, provided that states offer adequate assurances that the benefits are extended to those who are eligible. Precedent for a full year of coverage in Medicaid has been provided in other aspects of the Medicaid program. For example, the Balanced Budget Act of 1997 allowed states to guarantee a longer period of Medicaid coverage for children, such as 12 months, regardless of changes in a family's financial status.[16] As of July 2000, 14 states had implemented this option.[17] A similar approach could facilitate uninterrupted health insurance coverage for families that are moving from cash assistance to the workforce.

CONCLUDING OBSERVATIONS

Transitional Medicaid assistance can play an important role in helping individuals move successfully from cash assistance to employment, thus further advancing the goals of welfare reform. Without access to Medicaid coverage, these individuals, who are often in low-wage jobs, might have limited or no alternative health coverage and join the ranks of the uninsured. While our earlier work demonstrated that states varied in the extent to which families were participating in transitional Medicaid assistance, states that worked to minimize obstacles—particularly by reducing or eliminating income reporting requirements—had higher participation rates. Removing periodic reporting requirements would help further increase the use of transitional Medicaid assistance, provided that sufficient safeguards remained in place to ensure that only qualified individuals receive the benefits.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or Members of the Subcommittee may have.

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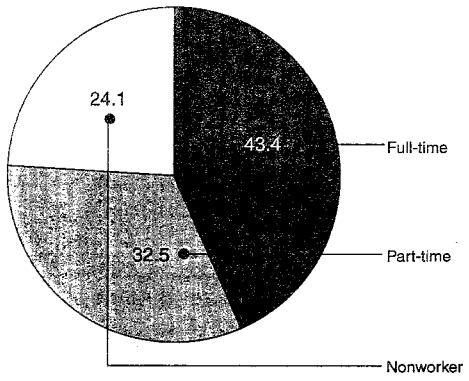
[16] See Pub. L. No. 105-33, § 4731, 11 Stat. 251, 519 (1997). According to an official from the Centers for Medicare and Medicaid Services (CMS), the transitional Medicaid assistance reporting requirements override other Medicaid provisions, such as continuous eligibility. Thus, according to CMS' interpretation, a state's use of continuous eligibility does not eliminate the periodic income reporting requirements for transitional Medicaid assistance.

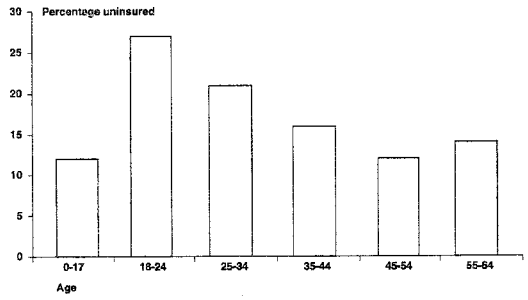
[17] Donna Cohen Ross and Laura Cox, *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures, Individual State Profiles* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, October 2000).

Figure 1: Percentage of Uninsured Nonelderly Adults That Were Employed, 2000



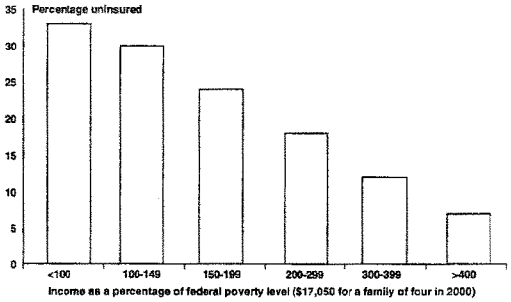
Source: GAO analysis of the March 2001 Supplement, Current Population Survey of nonelderly adults (18- to 64-year-olds).

Figure 2: Uninsured Population By Age Group, 2000



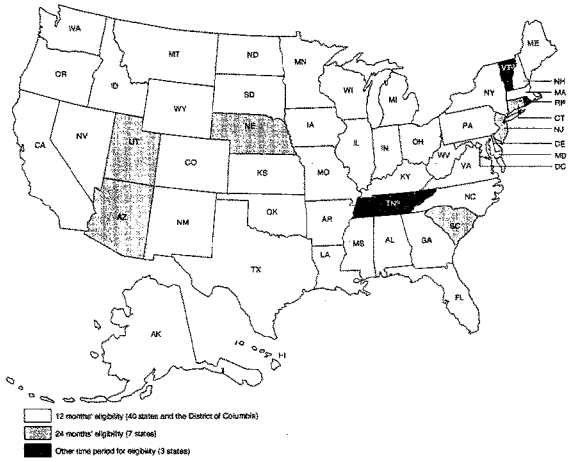
Source: GAO analysis of the March 2001 Supplement, Current Population Survey of nonelderly (under 65 years).

Figure 3: Uninsured Population, by Income as a Percentage of Poverty Level, 2000



Source: GAO analysis of the March 2001 Supplement, Current Population Survey of nonelderly individuals (under 65 years).

Figure 4: Number of Months States Provided Coverage for Transitional Medicaid Assistance, 1999



[a]Rhode Island and Tennessee provided 18 months eligibility, and Vermont provided 36 months.

Source: Health and Human Services Administration for Children and Families, Annual Report to Congress (Washington, D.C.: 1999).

Mr. BILIRAKIS. Thank you very much, Dr. Scanlon. Of course, my gratitude to all of you. The Chair would yield to Chairman Tauzin to inquire.

Chairman TAUZIN. Thank you, Mr. Chairman. Dr. Kaplan, in the time we have, let me ask you a couple of questions. In your written testimony you indicated that teachers cannot answer students' questions about prohibited topics in programs funded with abstinence only dollars. I assume you're talking about prohibited topics you mean contraceptives and sexually transmitted diseases, don't you?

Mr. KAPLAN. That's correct, yes.

Chairman TAUZIN. Now we have the Project Reality Game Plan curriculum before us. Chapter 4 deals specifically with sexually transmitted diseases and HIV and talks about condoms. It's my understanding that 30 plus programs receiving Title V funds use this curriculum. How do you reconcile that? This is the plan in front of me here. If it allows you to talk about sexually transmitted diseases, HIV and condoms and 30 programs use the curriculum, isn't it clear that any program funded under Title V can indeed provide information about contraceptives? It just can't promote or endorse contraceptive use. Isn't that correct?

Mr. KAPLAN. Yes. It's my understanding that the Title V prohibits programs from discussing how to use contraception or how to use condoms to actually prevent sexually transmitted disease.

Chairman TAUZIN. It can't promote or endorse the use, but it can discuss condoms. It can discuss HIV and sexually transmitted diseases, can't it?

Mr. KAPLAN. Well——

Chairman TAUZIN. That's what the game plan says.

Mr. KAPLAN. Right.

Chairman TAUZIN. In Chapter 4.

Mr. KAPLAN. Describing a sexually transmitted disease is one thing and getting an understanding of how you get it and how to prevent it is something else.

Chairman TAUZIN. I just find it a little inconsistent to say they can't answer questions in that program. I think they can, clearly, under the 30 plus programs that use this curriculum.

Let me also ask you, isn't it true that any school that has an abstinence only program can also provide sex education programs in other settings such as health, physical education classes which is often done?

Mr. KAPLAN. My understanding is if they do not use Title V funds, then they could have a comprehensive sex education——

Chairman TAUZIN. But even if they use Title V funds, they can have a separate one in health and p.e. courses, can't they?

Mr. KAPLAN. They probably could, yes.

Chairman TAUZIN. Yes, they can. Even more of a concern to me is Dr. McIlhaney's testimony. Amazing information. And I want to get your comments on this, Dr. Kaplan. He brought to our attention a fact that I had not heard before. I knew that there were more sexually transmitted diseases now than there were when we were growing up, at least to be concerned about. According to testimony today, there were basically two then. There are 25 today. Most of these are viruses that are not curable. But he also indi-

cates in his testimony that the National Institutes of Health Workshop on Scientific Evidence and Condom Effectiveness for Sexually Transmitted Disease Prevention reported that there is no evidence that condoms reduce the sexual transmissions of HPV, which is now found in 50 percent of sexually active women between the ages of 18 and 22. If that is true and I assume, Dr. McIlhaney, your facts are correct here, how do you not—how could you not recommend an abstinence only program being effective, when in 20 years these other programs have literally produced these kind of statistics today?

Mr. KAPLAN. Can I respond?

Chairman TAUZIN. Yes, please.

Mr. KAPLAN. You know, I think the thing that unifies all of us is that we're all very concerned about our youth.

Chairman TAUZIN. Well, yes.

Mr. KAPLAN. We're very concerned about the epidemic of STDs in this country which is higher than any other industrialized country. We're excited to see the pregnancy rates are coming down, but our pregnancy rates among teens are still the highest in industrialized countries. This is a very complex problem and one that is very difficult to resolve.

Chairman TAUZIN. Why wouldn't you want——

Mr. KAPLAN. Youth development programs are very important to engage our youth, not only because of STDs, but also because of substance abuse.

Chairman TAUZIN. Of course, of course.

Mr. KAPLAN. So anything that we can do to engage our youth and help them through this difficult period is very, very important.

Chairman TAUZIN. J.C. Watts puts it this way. He said if you knew that you had a program that was reducing accidents in a plant and you added a new program in that helped reduce it even further, why wouldn't you want to continue the second program, even if it reduced it 1 percent, 10 percent, 15 percent, if you knew this was helping, why wouldn't you want it reauthorized?

Mr. KAPLAN. In my practice I spend a tremendous amount of time talking with kids about abstinence and encouraging those kids that are not sexually active, not to become sexually active and yet at the same time I want to be sure that those kids understand how to prevent getting a sexually transmitted disease once they start having sex. It's that 100 percent——

Chairman TAUZIN. If they learn that condoms won't even prevent them, why wouldn't you want a program that emphasizes abstinence when that's the only program that's going to prevent some of these viral diseases.

Mr. KAPLAN. Condoms are not 100 percent. They're just not, but they're better than nothing.

Chairman TAUZIN. According to Dr. McIlhaney's testimony, there's no evidence at all that they reduce the sexual transmission of HPV virus. If there's no evidence they help at all, and abstinence clearly helps, why wouldn't you want that program as part of the Federal mix?

Mr. KAPLAN. According to the CDC and you probably need to talk to the CDC about this in their recommendations about the prevention of HPV they say in addition, the use of latex condoms has been

associated with a reduction in the risk of HPV associated diseases such as cervical cancer. Are they 100 percent? No, they're probably not. Does more research have to be done? Absolutely so.

Chairman TAUZIN. My time is up. But I want to finish with one thought.

Ms. Del Rosario, I just the read the article by this young man Clifford Mack and your words were so beautiful today when you talked about this program helping to build the character of these kids. It was this young man who basically makes my point. He ends by responding to the question why not wait? "It's why I wait because I am worthy of it." I am worthy of it.

Ms. ROSARIO. Yes.

Chairman TAUZIN. That statement really makes the case you've made today that you're building character while you may be protecting kids from all the statistics that Dr. McIlhaney and Dr. Kaplan have both cited to us. Thank you very much.

Mr. BILIRAKIS. Mr. Brown to inquire.

Mr. BROWN. Thank you, Mr. Chairman. We've talked today about families' eligibility for up to 12 months of coverage for Transitional Medical Assistance once they leave welfare and go back to work.

Ms. Mann, the problem that people have illustrated is that there are various reporting requirements making it difficult sometimes during this 12 months to the point that some people lose their coverage. Some have suggested Congress should allow the States the option to make these families automatically eligible for up to 12 months. Tell me what's good about that or not good about that, how that would change the system?

Ms. MANN. There are two different ways to go and they're not mutually exclusive. One would be to give States the option to eliminate the reporting requirements or to eliminate them all together. And an additional option may be to allow States to do what's called continuous eligibility, meaning once you're on TMA you're guaranteed the 12 months of coverage regardless of any fluctuations in income or changes in income. And Congress actually took exactly that step in the Medicaid program for children in 1997 in the Balanced Budget Act when it enacted the CHIP program, found that a lot of children would get into coverage, but would lose that coverage and the benefits of continuous eligibility and continuous access to care and allowed States the option to do continuous coverage. And so it's another direction you might want to go with respect to TMA.

Mr. BROWN. How many States have done that?

Ms. MANN. I believe at last count about 12 States have adopted that option.

Mr. BROWN. To shift to Dr. McIlhaney, to shift to the abstinence only, we debate the merits of abstinence only programs whether we should continue to fund them. I want to note that in his fiscal year 2003 budget, the President argues for the elimination of Federal programs that he says have not undergone rigorous evaluation. He feels so strongly about this he proposes to eliminate 35 programs entirely, simply because legitimately perhaps because there's no evidence that they are effective. He mentions—the elimination of programs such as dropout prevention, $10 million; alcohol abuse, reduction grants, $25 million; student mentoring programs, $17.5

million; foreign language assistance, $14 million; and on and on and on and on. Interestingly, by contrast, the President's budget continues funding abstinence only education despite the fact that it seems from evidence that such an approach has not proven effective. The budget states the President is committed "to stop the cycle of funding decisions based on wishes, rather than performance information."

My question is you were advisor to the Kirby Study, correct? And the study said currently there does not exist any research with reasonably strong evidence demonstrating that any particular abstinence only program actually delayed the onset of sexual intercourse or reduced any other measure or sexual activity. I'm told your job was to ensure the Kirby Study was accurate and reliable.

I also remember the technical work group for the evaluation of Title V abstinence education programs, the interim report which was delivered to this office here only an hour before the hearing, said empirical evidence on the effectiveness of abstinence education is limited. Moreover, most studies of abstinence education programs have methodological flaws that prevent them from generating reliable estimates of pregnancy impacts. That being two statements from organizations you've supported, been involved in, advised, now your testimony today says there's credible evidence showing that abstinence education is having an impact. Reconcile that, what those two studies and organizations said and what you are saying today in terms of impact.

Mr. MCILHANEY. First, I believe that there are reams of evidence, as I mentioned before. We've got 20 years of the dual message program studied by the very best academic institutions that show very, very little evidence of any kind of success at all. They almost never even measure pregnancy rates or STD rates. That's the first part of my answer to your question.

Second is, as far as my being a member of Doug Kirby's research task force for the National Campaign, there was no way to do a minority report on that and I dissented with him and he and I are friends. We've talked about this extensively. As a matter of fact, when the Monroe County program was reported and I mentioned it in my testimony I went to him and I said now Doug, are you going to advertise that study as broadly as you did Emerging Answers and he said well, no.

Let me remind you of two or three things. In all the programs that Doug Kirby reported in Emerging Answers, sort of implying that they were going to be successful, two thirds of those programs did not impact a student's sexual activity. Two thirds did not lower sexual activity. Half of them didn't even increase contraceptive use. So the title Emerging Answers is relatively appropriate. Now there are a number of emerging answers about abstinence education. The problem is unlike the dual message programs which have been around for a long time, have had lots of money for having studies done, these programs have been relatively unfunded until 1996. It takes 2 or 3 years. I think we can probably perhaps hear this from the fellow panelists that it takes 2 or 3 years to get a program even up and really going well. And that's why it's so important, in my opinion, to continue this funding. The other programs have not worked. It's been during their dominance that the STD and unmar-

ried pregnancy rates have grown the most. It's time for us to turn a corner and try something truly different and the best direction we have for this is to continue abstinence education, study it well, see what the results are. There are studies that are giving this good direction. I mention Monroe County. The Ad Health study, the biggest study ever done one adolescents in America show that kids who were taking pledges of abstinence and about 10 percent of boys and 15 percent of girls who had taken those pledges, above every other thing in their lives, that was the thing that was impacting their delaying the onset of sexual activity. That in itself is tremendous evidence about their success.

Mr. BILIRAKIS. I thank the gentleman. Ms. Del Rosario, how much of your life have you dedicated to working with at risk youth?

Ms. ROSARIO. Well, I've been in the system of education for the past 15 years and I've been dedicating 8 years to abstinence only education through Recapturing the Vision.

Mr. BILIRAKIS. Did you found that organization?

Ms. ROSARIO. I did.

Mr. BILIRAKIS. You're the Executive Director.

Ms. ROSARIO. I am.

Mr. BILIRAKIS. And you've been at it for 8 years. What's the average age of your target audience?

Ms. ROSARIO. Our program targets middle school to high schoolers and we have smaller populations of teen parents which range in age from 17 to about 20.

Mr. BILIRAKIS. Middle schoolers?

Ms. ROSARIO. That would be age about 11 to about 16.

Mr. BILIRAKIS. What's your percentage, roughly, of your entire targeted audience that falls in that category, middle school category?

Ms. ROSARIO. I'd say that 80 percent of those that we serve fall in the middle school age.

Mr. BILIRAKIS. Eighty percent?

Ms. ROSARIO. Yes, and then about 20 percent would fall in the other two groups.

Mr. BILIRAKIS. Well, our world is grateful to people like you to devote your life to these types of problems.

Ms. Del Rosario, we've heard testimony today and I certainly don't question Dr. Kaplan's dedication to the subject and his intent, but his testimony calls for a more balanced approach to educate the Nation's teens, that abstinence only education is not enough. You've been listening, I'm sure, to the others' testimony. It does an injustice to our youth by inadequately preparing them for real life, leaving them unprotected against sexually transmitted diseases and out of wedlock pregnancies. How would you refute those statements, if, in fact, you would refute those statements and how does your program prove those statements wrong?

Ms. ROSARIO. Well, firstly, I would begin by stating that I don't think that at all abstinence only education leaves them unprotected. As I mentioned before, every one in our State does receive at least one comprehensive sex education course before they graduate. So that's the first thing. No. 2, we do have $15.2 at the State level that are given for Title X and $8 million given for abstinence only education. So it's kind of very obvious to weigh the difference.

There's half nearly of those dollars are given for abstinence whereas the other portion is given——

Mr. BILIRAKIS. Your organization receives Title X dollars?

Ms. ROSARIO. We do not.

Mr. BILIRAKIS. You do not.

Ms. ROSARIO. We do not.

Mr. BILIRAKIS. Just Title V?

Ms. ROSARIO. Correct. I don't really foresee that there's anything about Title V abstinence only education that leaves kids uncovered or unprotected. As a matter of fact, it is the program that teachers toward the antecedence of teenage pregnancy which is a more holistic philosophy and concept.

Some of the outcomes of our program, for example, would be that 89 percent of those kids, these are the antecedents that I've speaking of, show a decrease in outdoor suspension; 80 percent a decrease in indoor suspension; 75 percent improve in their grade point average; 60 percent in attendance and 100 percent improve in self-esteem and this is demonstrated by an assessment instrument, an attitudinal survey that's administered pre and post-program intervention.

Mr. BILIRAKIS. Well, some information has been distributed to Members of Congress give the impression and the chairman got into this that those who receive funding under Title V cannot also receive family planning funding, so you've already told us that's not correct.

Ms. ROSARIO. That is absolutely not correct. Additionally, I am able to answer questions, if a student asks a question about—first of all, we teach on STDs and condom effectivity. However, we are able to answer questions. We're also directed to make direct referrals so that they're able to actually get the contraceptive help.

Mr. BILIRAKIS. In practice, that's what you do?

Ms. ROSARIO. That is correct.

Mr. BILIRAKIS. If you were able to receive Title X, could you receive Title X funding?

Ms. ROSARIO. I could via the stipulations. It must be a totally separate program.

Mr. BILIRAKIS. Yes, that was going to be my next question. How would you then treat that? How would you handle that?

Ms. ROSARIO. Oh, I think that first of all, you have to have a staff that's going to believe in what they're doing and even as we're electing teachers to teach the Recapturing the Vision program in the different States that we're in, one of the things that we look for, people that believe that they can bring change and that kids can perform and so I think that if you're going to do both types of programs, I would suggest that you have different staff and that is one of the dictates that our State officials do kind of ask that, they strongly encourage, let me say that, that you have separate staff for the Title X versus the Title V.

Mr. BILIRAKIS. Separate staff, separate locations, that sort of thing?

Ms. ROSARIO. Well, they don't stress the location, but just separate staff and separate programs so that you're doing, you're not mixing the message within one.

Mr. BILIRAKIS. You've already said that you're not prohibited from answering questions under Title V about critical topics such as sexually transmitted diseases, is that correct?

Ms. ROSARIO. That's true. This is correct.

Mr. BILIRAKIS. Oh yes, before I yield, the report, the NIH report that was referred to by the chairman in his questioning, entitled Scientific Evidence on Condom Effectiveness for Sexually Transmitted Disease Prevention dated June 12-13, I would ask unanimous consent it be made a part of the record. And I yield to Mr. Waxman.

Mr. WAXMAN. I thought Mr. Hall was very reluctant.

Mr. BILIRAKIS. And I trust he won't be chairing this committee any time soon, but when he does he can then chair it as he pleases.

In the meantime, I yield to Mr. Waxman.

Mr. WAXMAN. I will abide by your rules, Mr. Chairman.

Mr. McIlhaney, I just want to get some things straight about your views. Let's take as a given that total abstinence is always the best protection against pregnancy, transmission of sexually transmitted diseases including HPV and HIV. We all agree with that.

Do you agree though that despite our best efforts, people will engage in sexual activity including young people, even adolescents?

Mr. MCILHANEY. I think some will, but I think it's fewer than we have assumed.

Mr. WAXMAN. Some will.

Mr. MCILHANEY. Some will, but I'm not fatalistic about the number that most people would say.

Mr. WAXMAN. If you agree with the idea that some are going to be sexually active, even if condoms are not 100 percent effective, aren't people better off using a condom than going without if they want to avoid pregnancy and transmission of sexually transmitted diseases and HIV?

Mr. MCILHANEY. I think people need to be aware of the fact of what the NIH report said and I was—I was actually on that—in that group that made those findings. The research is very clear. If we looked at the world's research that condoms will fail for HIV transmission about 15 percent. There's a relative risk for people that, if they hadn't used condoms would have gotten infected; 15 percent of those would get infected even if they used condoms 100 percent of the time.

Mr. WAXMAN. Well, my question is, aren't they better off using a condom than not using a condom?

Mr. MCILHANEY. They're less likely to get infected with HIV.

Mr. WAXMAN. And less likely to get pregnant too, right?

Mr. MCILHANEY. They're less likely to get pregnant. The failures are much higher and as a physician, what I would do if my patients and what I would advocate programs do is advocate and teach and encourage what is the safest. As a matter of fact, the only reasonable way to avoid these problems.

Mr. WAXMAN. We all agree that that is the safest way, but we're talking about the millions of people who are going to engage in sexual activity notwithstanding your advice and my advice to them to the contrary, but even if we disagree, we know that condoms prevent transmission of STDs and HIV and can prevent pregnancy,

the question of HPV is still up in the air, but wouldn't you still prefer that a condom be used if sexual activity is occurring?

Mr. MCILHANEY. I think that there are different types of messages at different places. Okay——

Mr. WAXMAN. I'm not talking about the message. I'm talking about the reality. Wouldn't you prefer, if after the messages fail to stay abstinent, if there's going to be sexual activity that in order to prevent transmission of sexual diseases and pregnancy and HIV that you would prefer someone from a medical point of view use a condom?

Mr. MCILHANEY. I would prefer they protect themselves if they are insistent on having sexual intercourse and are not married individuals. The problem I have with what we're talking about here, at least what I understand we're talking about here at this hearing with these sexuality education programs though is that we have clear evidence that they have not been successful. As I said, two thirds of the programs that Doug Kirby talked about in Emerging Answers were ineffective in lowering sexual activity rates. Half of them were ineffective in getting people to use——

Mr. WAXMAN. The question also is do we have clear evidence that these abstinence only programs do work?

Mr. MCILHANEY. We have what we would call emerging answers on that, the fact that in Monroe County the actual pregnancy rates declined. With the pledge programs, we actually have one that now has reported declining pregnancy rates which is something the dual message programs almost never even talked about or even measured.

Mr. WAXMAN. Let me ask Dr. Kaplan, because I see my light is on yellow, so I'm going to get the gavel on me any minute now. What do you think about this?

Mr. KAPLAN. Well, the evidence on condoms, even more recent evidence since the NIH report really does document that condoms will prevent gonorrhea, will prevent chlamydia. There's a new study out that it will prevent the most common STDs, herpes, not HPV. The most common STDs, condoms can have an impact. HPV is still a major issue and any teenager who's going to have sexual intercourse has got to be aware that they are putting themselves at risk. There's no doubt about that. It's not 100 percent.

Mr. WAXMAN. Thank you. My time has expired. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Thank you, Mr. Waxman. Mr. Upton to inquire.

Mr. UPTON. Thank you, Mr. Chairman. Continuing the entire welfare reform bill is very critical to all of us here and some of us on both the Education and Workforce Committee as well as obviously this one, Energy and Commerce. I can remember well when Chairman Boehner presented the administration's bill that's been introduced and there were a number of us there that said where is the extension of Medicaid benefits? That was one of the most important things we were able to do and of course, we have jurisdiction of it here in this committee instead of the Education and Workforce Committee, so we're pleased to tell them we had jurisdiction and in fact, that was going to be continued. And I appreciated your testimony on that issue and as I met with a number of folks from my Family Independence Agency which is in essence

the welfare office in Michigan just yesterday, we talked extensively about making sure that that program continue, as well as the job training money which is so important to get people the skills needed to get into the workforce. And Dr. Scanlon and Ms. Mann, we appreciated your testimony for sure on that issue in its full detail and I would only ask Dr. Scanlon, I noted as a frequent visitor to our subcommittee on a whole number of topics, you talked only about extending Medicaid benefits. Does that mean that the GAO has not been brought into this sex education debate at all?

Mr. SCANLON. That's correct. We have not been asked.

Mr. UPTON. So with a letter, we can get you involved and indeed double versed. Is that correct?

Mr. SCANLON. We always try to respond to the requests.

Mr. UPTON. We'll look forward to that in the future. I think we might be able to work on a letter.

As my friend, Mr. Greenwood, indicated, he's the father of two teenage girls. I'm the father of one teenage daughter and soon to be a teenage son as well. And I visit a school every week across my District. One of the toughest meetings that I've had is to visit what I call the kids with kids, single moms, 15, 16 years old. They have a very rough life ahead of them. It's all we can do to encourage them to stay in school, to get that high school diploma and GED later, if they have to, because of all the pressures that are on them. As I have sat down with these kids on a number of occasions, even though I feel like maybe I'm still a kid and I turned 49 years old today and only last week was carded——

Ms. HARMAN. Will the gentleman yield?

Mr. UPTON. Yes.

Ms. HARMAN. On a bipartisan basis, we'd like to wish him a happy birthday.

Mr. UPTON. Well, I was carded only again last week twice.

I even made Paul Harvey in my hometown. But as much as I'd like to identify with these kids, with kids particularly, I know that peer pressure, I think, as I've said, to get them talking about all the problems that they have as new moms is awfully tough and it's that message I think works best, trying to dissuade kids to be sexually inactive and I think that it's important that we do look at these abstinence only programs and I know that when I talk to my Michigan folks and with my staff, Michigan, as I indicated in my opening statement, has done a remarkable job of decreasing not only abortion rates, but also pregnancy rates among teens and it's only been since the mid-1990's, I think it was 1996, that the abstinence programs have started in Michigan schools. And therefore, we're just beginning now to see the results of it which is finally, we're seeing a real decline. I guess the point that I would make as we listen to the testimony and read it as well some of the questions here that this important element of the legislation that we're going to consider and mark-up this week doesn't take a single dime away from the sex education, the programs that talk about condoms and the use of that, the parental involvement and all those different things, but this is a program that if the States decide to use it as Michigan has, where we match if $4 for every—$4 Federal dollars for every $3 State, it is a program that can be used to help supplement and get that message not only to young men, but obviously

as well to young women. My sense is that it works. Did you turn that thing on at the right time?

Mr. BILIRAKIS. This is green and this is red.

Mr. UPTON. I was going to say this must be DC and they got the red light cameras in the wrong spot. Okay, good.

Mr. BILIRAKIS. Anyhow your time is expired?

Mr. UPTON. It did?

Mr. BILIRAKIS. It's 26 seconds over. Did you have something you wanted to finish up, please feel free?

Mr. UPTON. I just wanted to make the point that it doesn't take a dime away. That in fact, it does work and we've seen real results in Michigan and that's why it's important that the rest of the country experience it as well if they choose.

Thank you.

Mr. BILIRAKIS. I thank the gentleman. Mr. Hall to inquire.

Mr. HALL. Mr. Chairman, thank you. I'll be fairly brief. You know, we talked about children. I had three sons and then a grandson until he was 20 years old before a little girl every showed up and now we have two little girls and I'm a lot more interested in abstinence now than I have been, but let me tell you this, abstinence, condoms, day-after pill and all that needs some additional thrust and I certainly plan, as long as I'm around, to stand at the corner of the high school drive and my grandchildren's home with a two by four and every damn little kid that comes by there on a bicycle that's a boy is going to be going a lot faster than he got headed there.

So what I'm saying and saying it probably poorly is it takes family and backup and love and care and kindness and understanding. I was County Judge in a rural county for 12 years when I had many young girls come to me. I was 24 then and looked about 19, but a lot of young girls come before me that their fathers had disowned because they were pregnant at a time when they were most needed were least understood. I think all everything we're talking about here gets back to family, gets back to educating the family and through them the children, but I thank you all for your testimony.

I don't think any of us have any problem with the abstinence thrust, that you think it's that and Ms. Del Rosario thinks it does maybe a little more than some of you do. She agrees that it can use help, it can use assistance and I think all of you have that same feeling, so—and by the way I think your State takes $4 million out in the abstinence program and I don't want to be bragging, but I think Texas takes the biggest amount which means they match, they have the greatest matching fund and it's around $5 million and that's very close where our two States are. But I think it's a good program. It's about $50 million a year and doesn't touch any other titles, Title XX money so far as I know, so I don't think we have any problem on supporting it and it's what goes with it and what we're going to put with it.

Now on the Transitional Medical Assistance part, and these are both reauthorizations and there's a battle for bucks and I'd like to add things to the Transitional Medical Assistance, but I'm not sure that we can and can survive the Senate or survive the Conference

Committee. I think you have to get what you can get when you can get it and that's what we're trying to do in these two bills.

I'd like to—this bill has a 6-month waiting period and I don't like that any more than anyone else, but if you give up on the 6-month waiting bill and also include the legal immigrants that were cut out in 1996 it doubles the cost and I think any conference committee that's going to be looking at this is going to be looking at the cost and I'd like to get what we can get and maybe come back at another year or another conference or in another bill to go further.

Do you, any of you have any problem with that thrust?

Ms. MANN. If I——

Mr. HALL. Other than the two by four part.

A two by four is a stick about this big around and yeah long.

Ms. MANN. I won't speak to the two by four. I'll just mention that one of the implementation issues around Transitional Medical Assistance, as both Dr. Scanlon and I mentioned, had to do with State implementation, change in their computer systems, making sure it worked, that when people left welfare, they were properly evaluated for Medicaid. Part of the problem of not having a longer extension of TMA is it leaves States wondering is it going to expire, is it going to continue and their willingness and ability to invest their time and their funds to improving the systems and boost participation may be dampened. That may be something to consider, certainly the fiscal constraints are clear.

Mr. HALL. Do you have any facts or figures on what the effect of it would be?

Ms. MANN. The effect of extending Transitional Medical Assistance?

Mr. HALL. Of curing the problem that you've set forth.

Ms. MANN. In terms of improving participation rates, we have and in my testimony I cite some information provided by the State of Indiana that did a number of improvements when it found it was losing a lot of people who were eligible and with those improvements no change in eligibility rules, just improvements in reaching people that they quadrupled the number of people who actually got TMA.

So the improvements can really make a large difference if the States invest the time and energy and to some extent the resources to make it work.

Mr. HALL. The cost effectiveness that you talk about is in results and not particularly in money?

Ms. MANN. Well, and then there's some cost effectiveness that Dr. Scanlon mentioned in terms of avoiding unnecessary hospitalizations and other care that could be more expensive down the line, if parents don't get their primary care initially.

Mr. HALL. I yield back my time, Mr. Chairman.

Mr. BILIRAKIS. Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman. I'd like to have a chat with you, Ms. Del Rosario. First of all, I want to tell you that I thought your statement was beautiful, elegant and I find very little, if anything, to disagree with. I liked what you had to say. And as I said, I'm the father of teenaged girls and I think you mentioned MTV. I cut MTV off from coming into our house when they

were 5 and 6 and they're still mad at me because I still won't let it come because I think it's part of the poisonous environment that our children are exposed to. I think the media is entirely irresponsible when you're talking about television, music, movies. It is a difficult, difficult thing to try to bring up a teenager to be safe in this society.

And I truly believe in abstinence as a value. I truly believe that these kids who are 14 and 15 and 16 and 17 need to be abstinent. They're far better off if they're abstinent. They're safer and they're healthier and their lives will probably be better if that's—if they are.

Here's my problem. I think that education, as I said in my opening statement, that education about abstinence is necessary for kids. I don't think it's sufficient. I think education about biology, including about how contraceptives work and don't work is necessary. I don't think it's sufficient. And I worry about what happens when you separate the two. I think society is reacting to the fact that many of our sex education courses have just been about the cold, hard facts without any discussion about emotional impact and no discussion of abstinence and values and what all of this means in the context of your lives and I understand why that was insufficient. And I understand the concern about dual message. I understand that, how do you say I think you're better off if you're abstinent, but in case you're not, here's how to use these methods of contraception. I understand that, but I also think I can remember enough about my own teenage years and I think I've been around. I've been a social worker. I've been around kids long enough to know that if they don't think that they're getting the full story from you, they're not going to believe that what they're getting is really wisdom. And I worry why it is that we can't integrate these messages with kids. Why it is that we don't trust the truth, why can't we tell kids the truth, the whole truth and nothing but the truth and if we believe in our hearts that—we believe the truth. We believe that kids are better off abstaining. We believe that contraceptives are not fullproof. We believe that kids can get hurt emotionally by premature sexual activity. Why can't we tell kids the whole truth and then they'll know, they'll trust us because when I look at this abstinence program, there's a lot of good stuff in here. I wouldn't mind having my daughters read this, but it also has the flavor of I'm only going to tell you so much, I'm going to give you one side of the story and I'm afraid kids go, we know what this is, this is propaganda. This is one side of the story. So my question is you seem to indicate that you think because you can answer any questions that are posed to you that you are providing a balanced education, but this whole notion of having to separate faculties and programs gives me the sense that the abstinence programs, abstinence only programs aren't giving kids the whole story, about trusting kids with the whole story and therefore are going to be suspect because they feel that they're not really getting the scoop.

Ms. ROSARIO. First of all, in response to your question, in my 8 years I've never heard, first of all, I've never had a student to ask me to give them a large amount of information about contraceptives, never. No. 2, I've never heard it stated that they felt that

anything was being withheld from them. I think what I want to address is this fact or fiction? If 9 out of 10 schools out of the 2 million our U.S.A. are offering comprehensive sex education, why would we think that they're not getting this information?

Mr. GREENWOOD. Let me interrupt you and I'll implore the chairman to give you enough time to get everything you want to say, but why would we want to have them divided at all? This notion that over here we have this insufficient——

Ms. ROSARIO. I was about to address that. I think it's because we are dealing with a mixed message. I think that's what I came into the ballgame not really validating. I didn't believe that was an issue. I'd heard it, but I did not believe until I heard it from the children. So now I am and I will have to disagree. I think there is no other way. If you're going to keep a mixed message out of the picture, I can't tell you on one side to do this and then tell you something else on the other side. However, if I withheld information from you or did not give you access, then I think that you have validity with your case. But the statement that you made, first of all, I believe that it's false. It's not correct. It's not what's happening.

Mr. GREENWOOD. Which statement is that?

Ms. ROSARIO. Meaning that kids are not getting both sides. I think that they're getting both sides not only in their school setting, from television. It's good that you did turn off MTV, but there are millions of other kids that don't have a good father like yourself at home, that are not able to turn off the television and they are getting those messages.

Mr. GREENWOOD. My question is we don't like dual messages to the extent that one message undermines the other. I understand that. But when we're saying 9 out of 10 kids are going to get this sort of sterile sex education that doesn't talk about their values and their emotions over here and then we would like to make sure they get this over here, they're getting two messages and it seems to me that that's a less effective way——

Ms. ROSARIO. If I could just state——

Mr. GREENWOOD. Than combining them.

Ms. ROSARIO. Let me give you an idea. If you have in one particular school, like our average high school has about 4,000 students, every one of those 4,000 students is going to get sex education. The amount that's going to get an abstinence only education might be less than 5 percent of that population. So I think that that changes your perspective on it. We're talking about 4,000 kids that are going to absolutely get that message at least once, sometimes twice, before they graduate.

Mr. GREENWOOD. And that's why I would support Federal funds——

Ms. ROSARIO. Abstinence only education is to make sure——

Mr. GREENWOOD. To make sure that no kid got sex education that didn't have an abstinence component.

Ms. ROSARIO. But then how do you address the issue of a mixed message? And then how do you also address——

Mr. GREENWOOD. By telling the truth, the whole truth and nothing but the truth and trusting the truth.

Ms. ROSARIO. This is the problem though. You can say that from here, but when it gets carried out down here, a lot of different things are going to transpire.

Mr. GREENWOOD. My time has expired.

Mr. BILIRAKIS. Mr. Green to inquire.

Mr. GREEN. Thank you, Mr. Chairman, and I want to follow up my colleague because of the mixed messages. I have a lot of follow-up and concerns. One is that as far as I know, the Federal Government outside of Title X has no comprehensive sex education requirement or funding for public schools. Is that correct? The 4,000 students you talked about, is that those 4,000 students, they're not receiving that because of something that Congress passed?

Ms. ROSARIO. I'm not aware.

Mr. GREEN. As far as I know, there's not.

Ms. ROSARIO. What I was discussing was in my written statement which are the Title V dollars which are 2 to 1 in most States.

Mr. GREEN. Okay.

Mr. MCILHANEY. And the Federal Government certainly funds CDC and to the Division of Adolescent School Health. There are programs that work. We say fund it extensively.

Mr. GREEN. But there's no requirement that we do that. CDC sets that out, but my local school district makes that decision.

Mr. MCILHANEY. Yes, but your local school decision might make a decision about whether to bring in a Title V program or not too.

Mr. GREEN. I know that's true. Let me go back to my colleague on the mixed message.

Ms. Del Rosario, in your testimony that abstinence plus programs are ineffective because they send children a mixed message, and I guess you have a lot of anecdotal information today, whether it's my colleague from Texas, Ralph Hall or myself, to have a son and a daughter who are now adults, but at what age do you think a child develops analytical skills necessary to comprehend all the information?

Ms. ROSARIO. I think that that can be gathered by looking at statistics. We're seeing that the onset of sexual intercourse is beginning earlier. That's why we targeted middle school because first of all they can understand the information, but also it's a time when the peer pressure is going to be mounting. It's going to be of the greatest impact to their future.

Mr. GREEN. So middle school, you think these children are having to make these decisions now. do you think they comprehend a mixed message? If all you say is just say no, I think you'll be laughed out of most of 6th and 7th grade schools.

Ms. ROSARIO. That's not what we do and that's not what I support at all. As a matter of fact, it's the opposite. I support a comprehensive program that teaches to the antecedence of out of wedlock births, teenage pregnancy.

Mr. GREEN. And I don't think most of us disagree. I want abstinence to be taught, but I also know I want to make sure that if they don't have the fortitude or the wherewithal or the ability to have the abstinence, we need to have them educated on how they can do and that's, I think, the concern from some of us on the committee.

Let me, when you talk about the need for background in the studies, both Dr. Kaplan and Ms. Del Rosario, references in your testimony, both of you all, leading organizations, there are no references, whether it's the Institute of Medicine, Surgeon General, National Institutes of Health or American Academy of Pediatrics, they all support comprehensive sex education. Is that correct?

Ms. ROSARIO. Well, let me go back and correct my last statement, because if you're using that term to refer to the type of sex education, I was saying comprehensive in terms of holistic education. I just want to make that clear.

Mr. GREEN. Well, again, maybe we're semantics, but I don't mind holistic as long as it includes everything.

Ms. ROSARIO. To make it clear that's called abstinence plus or comprehensive sex education. And I think we need to clarify our terms.

Mr. GREEN. Which again gives the child the information as children are making these decisions much earlier, as you testified, so they have all the information to make that decision.

Ms. ROSARIO. And they have gotten it already outside of the abstinence only course.

Mr. GREEN. And I'll mention this, I've been proud of using in speeches and I think some of my colleagues on both sides have used them. We've seen a decline in unwed pregnancies over the last number of years and I can't recall whether it's 4 or 5 years. Now I know and what you're saying maybe they are getting that mixed message now, but obviously something is working and I'd just like to continue it and I don't know if "Just Say No" will work with the typical child.

Ms. ROSARIO. Can I respond to that?

Mr. GREEN. Sure.

Ms. ROSARIO. One of the issues that I really think is very important is my recommendation as we even examine the reauthorization of abstinence funding, but also those programs that are awarded funding. I think that you can't just—you're trying to change a lifestyle by a 5-minute presentation telling kids to say no. I don't support that. What I'm saying is that holistic approaches such as those that are outlined in the congressional guidelines are what's necessary, approaches that are going to address the entire child, build self-esteem, character, deal with the value of marriage and family.

Mr. GREEN. Again, I don't think there's any doubt that we agree with that.

Ms. ROSARIO. But what I'm saying is that there are programs that are out there now that will give say five, 1-hour presentations on abstinence only and they might say say no and let me teach you one or two refusal skills. I say that my suggestion would be that we choose programs that are going to be a little bit more holistic.

Mr. GREEN. Mr. Chairman, could I get Dr. Kaplan to respond because——

Mr. BILIRAKIS. Very briefly now. It's really unfair to Ms. Harman and Mr. Pitts who have been sitting through the entire hearing and—very briefly, Dr. Kaplan.

Mr. KAPLAN. Sure, I just wanted to make it clear why we've seen a decrease in teenage births. Since the 1990's, the Centers for Dis-

ease Control has studied this and 75 percent of the decrease is due to more effective means of contraception, especially longer forms of contraception, Depo Provera and Norplant, really has resulted in the huge decrease that we've seen.

There's been some decrease in sexual activity and we've seen a delay of onset of kids becoming sexual active in that other remaining 25 percent, but the big change really has been more effective and better use of contraceptions and also an increased use of condoms during that period of time.

Mr. BILIRAKIS. Mr. Pitts, to inquire.

Mr. PITTS Thank you, Mr. Chairman. Ms. Del Rosario, thank you for your testimony. These handouts are marvelous. You mentioned an astounding statistic, a success rate I believe you said of 99.9 percent. Why is your program so effective? Tell us how you such a success rate?

Ms. ROSARIO. I think that first of all our program does address in the congressional guidelines, it's a very comprehensive program. It doesn't just want to give a message that kids parrot back, saying no, no. But first of all we begin to build the skills. We begin to build their value of themselves and we get them vested in their future.

I think that kids postpone sex and they also decide to value their future opportunities in not getting pregnant, if they feel that they have future opportunities. So that is a very vital component of the program. We don't just work also with the students that are in the program,but we also begin to work with their siblings and their parents. The whole purpose is to build stability in the family and to build the family, so that we're not just reaching one generation, but we're reaching three in the process.

And I think that when we're not trying to put the bandaid, but we're trying to find out why kids behave the way that they do and address that at the root source, versus let them continue to behave in a way that's unproductive for them and then just try to cover it the best way that we can, that's when we see true success.

There's another case that I cited in my written testimony. There's a program in Denmark, South Carolina that has similar outcomes. Their prevention rate was 59 percent in teen pregnancy during the 2½ years that they ran their program. At our local level, in the city of Miami, it is estimated that 14.2 births would occur in a population of 1,000 teens within a year's period. That would mean that by this time if you multiplied that by the 5,500 youth that we served that we should have a substantial amount of pregnancies beyond that, which we do. How do you explain it, particularly seeing that we're working with truly high risk populations who do not have proper role models, who have never seen—one of my biggest challenges was to build the value for marriage which is one of the reasons why I remember my mom told me, you know, you're going to don that beautiful white dress. We're going to go all out. I would say that to these kids and they would look at me like, hm, because they've never seen anyone married. Everybody cohabitates, you know, and these are the greater issues and that's what I believe that this legislation has allowed us to really address. School systems are under funded and over burdened. They cannot be the surrogates. But this funding allows us to teach those behav-

iors that make for successful living. It allows us to kind of bridge the gap. I'm not saying that there's any one program that's going to do everything. You don't understand what I'm saying. Don't misunderstand. But I'm saying this is a vital program. It has proven itself successful and like I said before, there are so many for it and so many against it, I think that we can all sit here all day long and come up with different studies that will document one stance or the other. But our program has been in effect for 8 years. Our research, we're research-driven, and it's sound. This is what has happened. So of course, I believe strongly in it and will continue to serve our communities with this approach.

Mr. PITTS Thank you. I just hope we find a lot of other States using your or similar programs.

Dr. McIlhaney, it's evident that you're well-qualified to speak about STDs. Would you speak about the long-term effects for adolescents who contract an STD? You mentioned you were on the NIH panel to determine the effectiveness of condoms and you spoke of HPVs. Can you just elaborate a little bit more about do condoms protect against the transmission of HPV and what are the effects of getting this virus?

Mr. MCILHANEY. I appreciate your asking that because I think the impact is much worse than most people realize. First, HPV is the most common sexually transmitted disease. As I said, it infects about 50 percent of sexually active adolescent females, even up to the age of 22. Most of those young people's bodies will clear it, but those of about 5 percent will probably develop abnormal Pap smears and a certain number of those will proceed to cancer. Human papillomavirus is a cause of 99 percent of cervical cancer in women, and as I said earlier it's a cause of almost all truly abnormal precancerous Pap smears of which we have an epidemic going on with kids today.

When any woman gets an abnormal Pap smear, if it persists and indicates pre-cancer, they may have to have a proceed done called a LEEP procedure where a portion of the cervix is cut out. If there's no immunity, they can get infected again with human papillomavirus and have to have that done again. That can ultimately, rarely, but occasionally, lead to prematurity or even infertility.

It's very clear there is no evidence at all that condoms prevent the sexual transmission of that.

Herpes is infected in about 1 in 5 Americans. There's been a 500 percent increase in Herpes among white adolescents over the past few years. And there are two problems with it. If people are Herpes infected, they are more susceptible and if a subsequent sexual partner has HIV to becoming HIV-infected. And if a woman has a Herpes outbreak at the time of delivery, it's possible that her baby can become infected. Half of those babies will die, half of them will become severely brain damaged. So although it doesn't happen very much, it's an extremely emotional issue for a woman who has Herpes and then might be delivering a baby 5 or 10 years later and still be having outbreaks.

Mr. PITTS I didn't mean to cut you off, sir.

Mr. MCILHANEY. We could just go on and on——

Mr. BILIRAKIS. I don't want you to go on and on.

Mr. MCILHANEY. I feel strongly about these problems and I saw them in my practice.

Mr. BILIRAKIS. I know that Mr. Pitts does too.

Mr. MCILHANEY. May I mention just one other?

Mr. BILIRAKIS. Please, sure.

Mr. MCILHANEY. Chlamydia. Chlamydia is infecting—adolescents have a special predilection to it. They seem to be especially susceptible to it. And it occurs, it reinfects girls so often that Johns Hopkins in their adolescent clinics who are studying chlamydia infection in young women found reinfection rates so often that they recommend that every adolescent in America who is sexually active, adolescent girl who is sexually active be tested for chlamydia every 6 months regardless of condom use. And although Dr. Kaplan mentioned some recent studies which I'm very familiar with about reduction of risk, he used the word "prevent" which I would object to because they reduce the risk. But the problem is the condoms leave the risk of Herpes, for example, even with these new studies of at least 35 to 50 percent. They leave the risk of chlamydia infection and so often it's asymptomatic. Girls don't know they have it. It leaves the risk of infection with HIV, even as I've mentioned. So I think that those things people need to know about.

Mr. PITTS Thank you very much.

Mr. BILIRAKIS. Ms. Harman.

Ms. HARMAN. Thank you, Mr. Chairman. Thank you for including me in this hearing and I really feel privileged to have listened to what I think is a very constructive and quite long conversation among us about this subject.

I voted for welfare reform in 1996. I'm a mother of four children, two of whom are female, and the subject of teen pregnancy and reducing teen pregnancy is on my mind a great deal personally, as I know it is on the minds of many members of this Panel. Two of my kids are still teenagers and this is a conversation we have often in my family.

I agree with Ms. Del Rosario that parents have to set limits and that parents have to provide clear lines, but I will tell you this is very hard to do, even if one is well-informed, one loves one's kids dearly, one believes in active parenting, one has read everything there is to read, and one went through all these issues oneself and hopefully came to reasonably wise conclusions.

Having said that, tomorrow, I plan to offer one or two amendments to this section of the bill because I want to give more flexibility to States. I come from California which has turned down the Federal funds under this title—turned down $30 million because my State believes that abstinence-only education doesn't work. It tried abstinence-only education from 1992 to 1994—under a Republican Governor—and concluded that it didn't work. I understand the data is emerging that these programs can work. That's terrific. But the present data in every piece of information I can find, including the bible here which Dr. McIlhaney worked on, shows that the programs that do work involve something more. And I feel, consistent with the President's view of the 2003 budget, that we should only fund things that we know work. He's canceled a number of programs in the budget, including dropout prevention, alcohol abuse reduction grants, student mentoring programs and so

forth because he can't find evidence that they work. So let's fund things that we know work. That's where I'm coming from. If we can prove in the future that abstinence-only works, that would be fine with me, let's fund it. In fact, if we can prove now, prove scientifically now that it works, let's fund it.

Having said all that I have a couple of questions to you, Ms. Del Rosario because you've obviously run a fabulously successful program over 8 years, well before these funds were available.

Are your participants self-selected or are they a general population pool in the area that you serve?

Ms. ROSARIO. Well, basically, they are referred or even kids come and volunteer and say that they want to take the course. That's basically how we get those students enrolled.

Ms. HARMAN. But they don't have to take it.

Ms. ROSARIO. Oh no.

Ms. HARMAN. So the pool that's there is there more or less, is this fair, because it wants to be there?

Ms. ROSARIO. Right.

Ms. HARMAN. There may be a different group than your general average public school group.

Ms. ROSARIO. It could be that their parents want them to be there, that they want to be there.

Ms. HARMAN. But there's some motivation, probably, personal motivation in each participant——

Ms. ROSARIO. Well, it's consequence-driven, so they understand that there's a lot of things that they have to follow the rules of. So if they're willing to do that, then they're in the program.

Ms. HARMAN. So you're not teaching the general population, you're teaching a self-selected population?

Ms. ROSARIO. The funds are so limited, you have to be self-selected.

Ms. HARMAN. And when you measure your results, you're measuring the results of the kids who stay in the program?

Ms. ROSARIO. Uh-huh.

Ms. HARMAN. So if some kids leave your program, you don't measure their results?

Ms. ROSARIO. Well, we're a part of the national evaluation.

Ms. HARMAN. What does that mean?

Ms. ROSARIO. Congress commissioned a study, Mathematic Policy Research has begun that study. I believe we're in year 3. And we're one of the top six programs in the Nation that was chosen for Title V funding to be evaluated. So in that study, they are using cohort groups and program students and they're tracking them for a period of about 4 to 5 years.

Ms. HARMAN. Four to 5. That was my next question. So they do track kids who have left your prgram?

Ms. ROSARIO. Yes.

Ms. HARMAN. But I'm still correct that the kids in your program are a self-selected group, not a random group?

Ms. ROSARIO. See, I'm just not clear on what you mean by self-selected.

Ms. HARMAN. I mean that they want to be there.

Ms. ROSARIO. Yes. So do the control group.

Ms. HARMAN. Okay. Time is short. I just have one other question to you. You said several times that 9 out of 10 schools offer comprehensive sex information. What is the basis for that statement?

Ms. ROSARIO. It's in my written statement. It was data that I researched. I think there's three States that allow parents to absolutely protest and remove students from that sex education course, but basically all of the States do.

Ms. HARMAN. Who funds that comprehensive——

Ms. ROSARIO. I know that some of the funding is done under Title X, but it's not done at the school level. I'm not really certain on what constitutes——

Ms. HARMAN. Right. My understanding is that Federal funding under Title X is not for school-based education. Title X does provide for family planning and health care and does provide for some teen services, but they're at medical centers, not in schools.

Ms. ROSARIO. There is some because I work at some of the centers where we do have programs that they're offering onsite, condoms and any type of contraceptive use that the kids might need. And those are those types of schools that are called Schools of Choice.

Ms. HARMAN. Okay, but I would appreciate it if you could provide us with—Mr. Chairman, I'd like to request this, the justification for that statement that 9 out of 10 schools offer this education and where the funding comes from because my understanding is that most of it does not come from Federal funds. Some States have these funds, some States don't have these funds. We're talking here about extending a Federal program—welfare reform—and trying to reduce teen pregnancy, to provide some funds for that. And so it is my view, Mr. Chairman, that the funds we provide in this Federal program to reduce teen pregnancy should go to programs that work. I don't think anyone is really disagreeing with this idea, and funds should be available in schools for programs that work.

Ms. ROSARIO. I'll also try to include additional information such as Title V funding that is done through wages or TANF dollars. We received initially those dollars to provide comprehensive sex education and we elected to do abstinence only and had to really fight to be able to do that, so I know those are another set of funds that are under TANF that we're able to do sex education with.

Ms. HARMAN. Well, I appreciate that. I'd appreciate maybe staff can clarify that for me too before tomorrow. I want to be sure that what I talk about is based on fact. Does any, I think, even though the light is green, I have a feeling it's red.

Mr. BILIRAKIS. Very brief. We've got to finish up.

Mr. KAPLAN. Yes, I think you're correct, that there are not Federal dollars for family planning in the schools and actually, in Colorado, my state, you know, it's pretty sketchy as to how much comprehensive sex education is actually offered and there was a study in family planning perspectives in 2000 and the thing that I'm concerned about is that we've seen a real deterioration in comprehensive sex education. In this study they found in 1999 that 25 percent of secondary teachers were teaching abstinence only as the only way to prevent pregnancy and STDs, so we've sort of lost the general education that kids need to have about these problems.

Ms. HARMAN. Well, thank you again, Mr. Chairman for allowing me to participate.

Mr. BILIRAKIS. Dr. McIlhaney, I know you're anxious to say something, are you?

Mr. MCILHANEY. Sure, sure.

Mr. BILIRAKIS. You look like you're chomping at the bit.

Mr. MCILHANEY. May I, sir?

Mr. BILIRAKIS. Very briefly. Okay, first, I'll help with providing the data about the Federal funds for sexuality education because we've recently added that up to well more than $135 million, almost up to $400 million that will help provide some information for that through all sorts of agencies, Agriculture, Interior and surprisingly, other places.

I'd just like to mention one thing and that is that there's sort of this—it almost feels like sort of this dreamy thing about the comprehensive sex ed., that they truly are comprehensive. They are far from comprehensive. The abstinence element, as a matter of fact, in many of these programs that even are sometimes referred to as abstinence plus programs have either no abstinence information at all or very little.

Another problem with them——

Mr. BILIRAKIS. You're referring to Title V programs?

Mr. MCILHANEY. No sir. I'm referring to the abstinence plus or comprehensive sex education or these programs that we've been talking about as well, providing full information. They don't do that. As a matter of fact, abstinence part of those programs is very minimal.

Doug Kirby himself also showed that unless a teacher feels strongly that the young person can access this information, understand it and use it, that it's not going to be effective. We understand that even for Algebra teachers, they've got to believe kids can understand Algebra. And there are essentially none of these programs I know of that those who really understand abstinence programs would say that the abstinence part of these dual-message programs would even be considered an abstinence education program.

As a matter of fact, in most of these programs, we've seen some recent stuff that would say that the information in these dual-message programs is really alarming and is something if parents and many of you knew, were there, you'd probably be almost shocked about. So these are not comprehensive programs in providing either kind of message for kids. We have to—I totally agree with Ms. Del Rosario that young people who are taught about abstinence have to be taught by somebody who truly believes that those young people can understand this and will do it.

Mr. BILIRAKIS. Ms. Del Rosario, let me ask you, do you all, those of you who work in the Title V programs around the country, the 49 States, do you share, the way you present the programs and the results and the success rate, etcetera?

Ms. ROSARIO. We do.

Mr. BILIRAKIS. You do.

Ms. ROSARIO. Under SPRANS and under Title V abstinence only dollars. It's even contractually stated that you have to gather at

least once a year and that's what we do to really strengthen the programs and to perfect them.

Mr. BILIRAKIS. Are you confident that the other Title V programs use the same concept that yours does?

Ms. ROSARIO. Some of them do. I've traveled and I've been speaking around the country and I've seen some that are and some that are not. And that's why I made that suggestion about the types of programs that we're looking at. Because I mean we can have a good intention, but if we fund poor programs or weak programs, I don't care what their message is, it's not going to work.

Mr. BILIRAKIS. Well, I'd really like to thank you all. You're a very respected panel of witnesses. Obviously, you all care about this issue. We didn't hear too much from Ms. Mann and Dr. Scanlon, I guess, because we sort of got caught up in this other more controversial issue.

Mr. BROWN. Mr. Chairman?

Mr. BILIRAKIS. I'll recognize you in a moment, sir, but there's in the national newspaper, Today, there's an article that highlighted the issue of abstinence only education and one of the teens interviewed in the piece mentioned and I quote, "the abstinence messages are getting through" according to this teen. So I guess she sort of agrees with Ms. Del Rosario.

Well, tomorrow we have our hearing and—I mean our mark-up. And not much time in between and it's unfortunate, but if you all have—and I'll yield to Mr. Brown in a moment—but if you have any suggestions, all of you in terms of issues, that we should be discussing or maybe the legislation, please feel free to pass that on to us.

Mr. Brown?

Mr. BROWN. Thank you, Mr. Chairman. I'd like to thank the panel, too.

Two years ago, this subcommittee passed a 1-year extension of the transitional Medicaid program. We also passed under the leadership of Chairman Bilirakis two improvements to TMA, one was a State option to waive the reporting requirements which Dr. Scanlon, Ms. Mann mentioned. The other is an exemption from the TMA requirements for States that already broadly covered the population, this population up to 285 percent of poverty. These improvements, as you know, Mr. Chairman, never made it into law last year, but I hope—2 years ago—but I hope that we can work together. I know tomorrow we won't make that change, but through this process we can work together to do that, if we could.

Mr. BILIRAKIS. Well, and you made the point in your opening statement, Mr. Brown, that there are no new additional Medicaid dollars in the budgets, so in order to have these transitional funds, we're going to have to find some sort of an offset and hopefully we can all work together, because I know we all want that to take place.

Mr. BROWN. And I also would ask unanimous consent to enter this into the record. This is the endorsement by members of the clergy and lay religious leaders of the Planned Parenthood Federation, America's Statement on Comprehensive Sexuality Education.

Mr. BILIRAKIS. Without objection, that will be the case.

[The material follows:]

PREPARED STATEMENT OF PLANNED PARENTHOOD FEDERATION OF AMERICA

CLERGY ADVISORY BOARD

We, the undersigned, are clergy and lay religious leaders who represent diverse religious traditions and come from all walks of life. We believe that an individual's sexuality must be affirmed as an essential dimension of being human. Concerned about the sexual health of our country, we strongly support the bold and courageous recommendations of the "Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior" for more knowledge, more services, and more open discussion.

Accordingly, we call on our elected leaders to ensure that our young people receive medically accurate and balanced sexuality education.

Speak the Truth

As clergy, we have a responsibility to remind our congregations, our communities, and our elected leaders that both the Hebrew Bible and the New Testament, as well as the teachings of other religious faiths, view the body and the physical world as a sacred arena in which God acts. Did not God bless human beings with the opportunity to bear children as a singular sign not only of the sacredness of life but also as a sign of their capacity for sexual intimacy?

Yet we treat human sexuality as inherently dangerous and off-limits for discussion. Discomfort with their own sexuality inhibits many parents from talking with their children about this most natural part of life. A lack of information and understanding about sexuality also contributes to painful discrimination against sexual minorities.

Our sexuality is God given, and so, too, is the command that we instruct our children so that they will gain understanding and the ability to make wise choices.

Fund Programs That Work

The current debate over sexuality education in the nation's public schools is one more example of how theological abstraction and moral absolutes have been permitted to substitute for common sense and compassion, not to mention the lessons that medicine and science can teach us.

For the sake of our young people, we urge our elected leaders not to ignore the expert findings that there is no reliable, scientific evidence to demonstrate that abstinence-only sexuality education works, while there is substantial evidence to show that comprehensive sexuality education has been successful in preventing teen pregnancy.[1]

Substituting dicta for instruction stifles the kind of open discussion that fosters the development of healthy and responsible attitudes toward our God-given gift of sexuality.

As community leaders who care about the well being of young people, we, like a substantial majority of Americans, encourage teens to abstain from sexual intercourse. But, like a substantial majority of Americans, we also recognize that many will not.[2]

Giving young people complete information does not influence them to engage in sexual activity any earlier—that's what the research shows.[3] How can we, in all good conscience, deny young people knowledge that would protect them from becoming parents before they are ready to have children and would also protect them from either contracting or spreading sexually transmitted infections?

Don't Discriminate

Finally, we believe that public funding that supports only abstinence-only education discriminates against the religious denominations that support comprehensive sexuality education. Twelve denominations favor curriculums that discuss abstinence as one option and include information about all aspects of human sexuality, with the objective of developing sexually healthy adults who can make responsible choices about their reproductive lives.[4]

Many faith traditions teach that children must be treated, with due allowance for their ages, as responsible persons who can make critical decisions about their lives. Each child has a conscience. Each can be taught to become a reasoning and reason-

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[1] See Douglas Kirby, *Emerging Answers* (Washington: The National Campaign to Prevent Teen Pregnancy, 2001).

[2] Jacqueline Darroch, et. al., "Changing Emphasis on Sexuality Education in U.S. Public Secondary Schools." *Family Planning Perspectives* 32(5): 204, 205 (2000).

[3] See Kirby, op. cit.

[4] Debra Haffner, *A Time to Speak: Faith Communities and Sexuality Education* (N.Y.: SIECUS, 1998).

able person. Each must be taught about human sexuality, so that each can make informed and responsible choices about his or her sexual life, including the choice to remain abstinent. As an integral part of this process, our young people have a right to the best information possible. We pledge to dedicate ourselves to ensuring that they receive nothing less.

Title	First and Middle Name	Last Name	Organization/Affiliation	City	State
Chaplain	Lesley	Adams	St. John's Chapel	Geneva	NY
Ms.	Janis	Adams	Presbytery of Cincinnati	Cincinnati	OH
Dr.	Michael J.	Adee	First Presbyterian Church	Sante Fe	NM
Rev.	Julia J.	Aegerter	Unitarian Universalist Church of Evansville	Evansville	IN
Rev.	Clifford L.	Aerie	United Church of Christ	Cleveland	OH
Rabbi	Heather	Altman	Bet Torah	Mt. Kisco	NY
Rev.	David A.	Ames	Episcopal Chaplain, Brown University	Providence	RI
Rev.	Wayne R.	Anderson	United Methodist Church	Louisville	KY
Rev.	Nancy L.	Anderson	Minnehaha UCC	Minneapolis	MN
Rev.	Alice V.	Anderson	The New York Ave. Presbyterian Church	Washington	DC
Rev. Dr.	Susan R.	Andrews	Bradley Hills Presbyterian Church	Bethesda	MD
Rev.	Susan C.	Armer	St. Matthew's Episcopal Church	Auburn	WA
Rabbi	Benjamin	Arnold		Amherst	NY
Rev.	Mark E.	Asman	Trinity Episcopal Church	Santa Barbara	CA
Rev.	Theodore A.	Atkinson	Oxford Presbyterian Church	Oxford	PA
Rev.	A.E.	Aurand	Incarnation Lutheran Church	Cedarhurst	NY
Rev.	Louisa M.	Baer	Blue Ash Presbyterian Church	Cincinnati	OH
Rev.	Brian	Bagley-Bonner	Newbury United Community Church	Newbury	OH
Rev.	David	Bahr	Archwood United Church of Christ	Cleveland	OH
Rev. Dr.	Warner M.	Bailey	Ridglea Presbyterian Church	Fort Worth	TX
Rev.	Melvin L.	Bailey	Shiloh Baptist Church	Tulsa	OK
Rev.	Darline D.	Balm-Demmel	UMC	Des Moines	IA
General Presbyter	Philip W.	Barrett	General Presbyter-Presbytery of Des Moines	Des Moines	IA
Rev.	S. John	Bartley		Atlanta	GA
Rabbi	Pamela Frydman.	Baugh	Or Shalom Jewish Commuity	San Francisco	CA
Rev.	Eugene C.	Bay	Byrn Mawr Presbyterian Church	Bryn Mawr	PA
Rev.	Paul	Beckel	First Universalist Unitarian Church	Wausau	WI
Rev.	Silvia R.	Behrend	First Unitarian Church of Salt Lake City	Salt Lake City	UT
Rabbi	Martin P.	Beifield, Jr.	Congregation Beth Ahabah	Richmond	VA
Rev.	Emmy Lou	Belcher	Unitarian Universalist Congregation of Grand Traverse.	Travers City	MI
Rev. Dr.	Mark	Belletini	First Unitarian Universalist Church 93 W. Weisheimer.	Columbus	OH
Rev.	Russell L.	Bennett	Fellowship Congregational Church UCC	Tulsa	OK
Rev.	Eric	Bentrott	Pilgrim Congregational Church	Cleveland	OH
Rev.	J.C.	Berbiglia	Presbyterian Church (USA)	Helotes	TX
Rabbi	Peter S.	Berg	Temple Emanu-El	Dallas	TX
Rev.	Julie	Bergdahl	Redeemer Lutheran Church	Plattsburgh	NY
Brother	Clark	Berge	Society of St. Francis	Mount Sinai	NY
Rabbi	Jonathan	Biatch	Beth El Hebrew Congregations	Alexandria	VA
Rev.	Mark	Bigelow	Congregational Church of Huntington, UCC	Huntington	NY
Rev.	Wes	Bixby	Smith Memorial Cong Church, UCC	Hillsboro	NH
Rev.	Kathleen A.	Bishop	Unity Church	Fort Lauderdale	FL
Rev. Dr.	Nadean	Bishop	MN Religious Coalition for Reproductive Choice	Minneapolis	MN
Rev.	Cynthia L.	Black	Parish Church of Christ the King at the Cathedral.	Kalamazoo	MI
Rev.	James C.	Blackburn	Diocese of Maryland	Baltimore	MD
Chaplain	Lee	Blackburn		Kansas City	KS
Vicar	Martha	Blacklock	St. Mary the Virgin Episcopal Church	Keyport	NJ
Rev.	Rebecca M.	Blackwell		Philadelphia	PA
Rev.	Rosalee	Blake	UMC	Chicago	IL
Rev.	Dallas A.	Blanchard		Pensacola	FL
Rev.	David M.	Blanchard	Unitarian Universalist Association	Andover	MA
Rabbi	Barry H.	Block	Temple Beth-El	San Antonio	TX
Rev.	Eddie	Blue	Church of the Holy Trinity (Episcopal)	Baltimore	MD
Cantor	Sheri	Blum	Congregation B'nai Israel	Bridgeport	CT
Mr.	Theodore A.	Blunk	Old Stone Presbyterian Church	Cleveland	OH

Title	First and Middle Name	Last Name	Organization/Affiliation	City	State
Rev.	Melinda	Bobo	St. Martin's by the Lake Episcopal Church	Minnetonka Beach	MN
Rabbi	David	Bockman	Beth Meyer Synagogue	Raleigh	NC
Rev.	Steve	Bohlert	CPCUCC	Comstock Park	MI
Rabbi	Elizabeth	Bolton	Congregation Beit Tikvak	Balitmore	MD
Rev.	Edward K.	Brandt	Red Clay Creek Pres. Church	Wilmington	DE
Rev.	Robert L.	Brashear	West-Park Presbyterian Church	New York	NY
Rabbi	Balfour	Brickner	Stephen Wise Free Synagogue	New York	NY
Rev.	Harlan	Breininger	United Church of Christ	Jim Thorpe	PA
Rev.	J. Wesley	Brown	United Methodist Church	Santa Barbara	CA
Rev.	Robert O.	Browne	Presbytery of Santa Fe	Albuquerque	NM
Rev.	Ellen A.	Brubaker	United Methodist Church	Grand Rapids	MI
Reverend	Daniel E. H.	Bryant	Christian Church (Disciples of Christ)	Eugene	OR
Rev.	Roger	Buchanan	Carversville Christian Church	Perkionmenville	PA
Rabbi Emeritus.	Gustav	Buchdahl	Temple Emanuel	Baltimore	MD
Rev.	Kathleen	Buckley	Chaplain, St. Lawrence University	Canton	NY
Rev.	Daniel	Budd	First Unitarian Church of Cleveland	Shaker Heights	OH
Rev.	Cynthia S.	Bumb	United Church of Christ	St. Louis	MO
Rev.	Larry V. R.	Bunnell	Presbyterian Church (USA)	Klamath Falls	OR
Ms.	Angela	Buxton	UMC, Brunswick	Brunswick	ME
Cantor	Norma Bruce	Byers	American Conference of Cantors	Manchester	NJ
Dean	John A.	Cairns	Fourth Presbyterian Church	Chicago	IL
Rev. Dr.	Kristina	Campbell	SW Conference, United Church of Christ	Scottsdale	AZ
Rev.	Steven	Carlson	Emmaus Lutheran Church	Eugene	OR
Rev.	Walter	Carlson	UMC	Pana	IL
Cantor	Susan	Caro	Temple Judea	Tarzana	CA
Rev.	Katherine L.	Carpenter	PCUSA	Lynchburg	VA
Rev. Dr.	Wayne	Carter	Trinity Episcopal Church	Pharr	TX
Rev.	Ashli	Cartwrigt-Peak	Little Eagle Christian Church	Westfield	IN
Rev. Dr.	Ignacio	Castuera	St. John's United Methodist Church	Los Angeles	CA
Rev. Dr.	Kenneth	Cauthen	Professor of Theology	Rochester	NY
Rev.	Barbara	Chaapel	First Presbyterian Church	Philadelphia	PA
Rev.	Shirely M.	Chan	Riverside Salem UCC	Eden	NY
Rev. Dr.	Gary W.	Charles	Old Presbyterian Meeting House	Alexandria	VA
Rabbi	Joshua	Chasan	Ohavi Zedek Synagogue	Burlington	VT
Rev.	Pamela C.	Cheney	United Church of Christ	Cleveland	OH
Rev.	Barbara	Child	St. John's Unitarian Church	Cincinnati	OH
Rev. Dr.	Bruce	Chilton	Church of St. John the Evangelist	Barrytown	NY
Rev.	Richard	Chrisman	Central Congregational Church	Jamaica Plain	MA
Rev.	Micahel O.	Christensen	Warwick United Church of Christ	Newport News	VA
Rev. Dr.	Diane	Christopherson	United Church of Christ	Ann Arbor	MI
Rev.	Robert	Clark		Denver	CO
Rev.	Peggy C.	Clason	Unitarian Universalist Society of Cleveland	Cleveland Hts.	OH
Rev.	Maryell	Cleary	Unitarian Universalist Church of Greater Lansing	East Lansing	MI
Rev. Prof.	Howard	Clinebell		Santa Barbara	CA
Rev.	Charles	Cloughen, Jr		Sparks	MD
Rev.	Edward A.	Clydesdale		Newark	NJ
Pastor	Robert C.	Cochran	Lutheran Campus Ministry, ELCA	Kalamazoo	MI
Rev.	Matthew	Cockrum	First Unitarian Society of Milwaukee	Milwaukee	WI
Rev.	Anne G.	Cohen	United Church of Christ	Los Angeles	CA
Rev.	Helen Lutton	Cohen	First Parish of Lexington	Lexington	MA
Rev.	Ernestine B.	Cole	Columbia Theological Seminary	Decatur	GA
Rev.	Ann Marie	Coleman	University Church	Chicago	IL
Rev.	John	Collins	NY Conference, United Methodist Church	New York	NY
Dr.	Shelia	Collins	NY Conference, United Methodist Church	New York	NY
Rev.	Cyril C.	Colonius		Kalamazoo	MI
Rev.	Lucretia	Cooksy	Jubilee United Methodist Church	Duncanville	TX
Rabbi	Sigma	Coran	Williams College	Williamstown	MA
The Rev.	Sandra Lee	Cordingley	Christ Episcopal Church	West River	MD
Rev.	Mary Jane	Cornell		Atlanta	GA
Rev.	Monica	Corsaro	Chaplain, Planned Parenthood Affiliates of Washington State.	Seattle	WA
Rev.	Pamela	Cranston	St. Cuthbert's Episcopal Church	Oakland	CA
Rabbi	Meryl	Crean		Elkins Park	PA

Title	First and Middle Name	Last Name	Organization/Affiliation	City	State
Rev.	James	Crowder	Episcopal Church	Cockeysville	MD
Rev.	Thomas L.	Culbertson	Emmanuel Episcopal Church	Baltimore	MD
Rev.	Richard A.	Cullen	Auburn United Methodist Church	Auburn	ME
Rev.	Arthur E.	Curtis	Unitarian Universalist (ret.)	Anchorage	AK
Rev.	Ben	Dake		Cottage Grove	OR
Rev.	Beverly	Dale	Christian Association University of Pennsylvania	Philadelphia	PA
Rev.	Nancy C.	Danson	United Methodist Church	San Jose	CA
Rev.	Wayne	Darnell	Inter Faith Ministry	Ft. Lauderdale	FL
Rabbi	Andrew	Davids	Union of American Hebrew Congregations	New York	NY
Rabbi	Josef A.	Davidson	B'nai Zion Congregation	Chattanooga	TN
Rev.	Tom	Davis	Chair, PPFA Clergy Advisory Board	Saratoga Springs	NY
Rabbi	David	Davis	Vanderbilt University	Nashville	TN
Dr.	Holly Haile	Davis	Padoquohan Medicine Lodge; and Member of the Long Island Presbytery, PCUSA.	Southampton	NY
Rev.	Virgie J.	Davis	Zion United Church of Christ	Dale	WI
Ms.	Peggy	Davis-Herod	South Haven UCC	Bedford	OH
Rev.	Lisa W.	Davison	Christian Church (Disciples of Christ) & Lexington Theological Seminary.	Lexington	KY
Rev.	Michael	Davison	Christian Church In Kentucky	Lexington	KY
Rev.	Lorraine	De Armitt	Southold United Methodist Church	Southold	NY
Ms.	Adele	de Ryk	Parish Nurse, All Saints Episcopal Church	Loveland	CO
Rev.	Michael R.	De Vaughn	Carter Chapel CME Church	Amarillo	TX
Rev.	Robert C.	Dean	Episcopal Church	StaffordVA.	
Rev.	Gregory	Dell	Broadway United Methodist Church	Chicago	IL
Rev.	Robert	Dell	UCC	Sandwich	IL
Ms.	Jean	DeVoll-Donaldson.	Lutheran School of Theology at Chicago	Chicago	IL
Rev.	William A.	DeWolfe	Unitarian Universalist Church	Damariscotta	ME
Rabbi	Barry	Diamond	Temple Emanu-El	Dallas	TX
Mr.	Richard	Dickens	West End Collegiate Church	New York	NY
Rabbi	Lucy	Dinner		Raleigh	NC
Rabbi	Fred S.	Dobb	Adat Shalom Reconstructionist Congregation	Bethesda	MD
Mr.	Donald F.	Doering		Amherst	NY
Rev.	Roy	Donkin	Emmanuel Baptist Church	Albany	NY
Rev.	Cheryl D.	Donkin	Emmanuel Baptist Church	Albany	NY
Rev.	Jack	Donovan	Unitarian Universalist Fellowship	Gainesville	FL
Rev.	Randall	Doubet-King	United Church of Christ	Chicago	IL
Rev.	Nancy	Doughty		Traverse City	MI
Rev.	Elizabeth Morris.	Downie	St. Jude's Episcopal Church	Fenton	MI
Rabbi	William	Dreskin	Woodlands Community Temple	White Plains	NY
Ms.	Barbara	Drew		Newton	PA
Rev.	Sarah B.	Drummond	University Christian Ministries	Milwaukee	WI
Rev.	Karen N.	Dungan	First United Methodist Church	Osage	IA
Rev. Dr.	Eileen	Dunn	Director of Women's Programs, Green River Community College.	Auburn	WA
Rev. Dr.	Lyle J.	Dykstra	Limestone Presbyterian Church	Wilmington	DE
Ms.	Karen	Dyste	Central Presbyterian Church	Eugene	OR
Rev.	Rose	Edington	Unitarian Fellowship of Athens	Athens	OH
Rev.	Jan	Edmiston	Fairlington Presbyterian Church	Alexandria	VA
Rev.	Carol	Edwards	Unitarian Universalist at Live Oak	Santa Barbara	CA
Rev.	Janet E.	Eggleston	UMC	Springfield	PA
Rabbi	Dan	Ehrenkrantz	B'nai Keshet	Montclair	NJ
Rev.	Lauren D.	Ekdahl	Trinity United Methodist	Lincoln	NE
Rev.	Jim	Eller	All Souls UU Church	Kansas City	MO
Rev.	Steve	Ellis	Episcopal Church of St. John the Baptist	Capitola	CA
Rev. Dr.	Marvin M.	Ellison	Bangor Theological Seminary	Portland	ME
Rev.	Nancy Nelson.	Elsenheimer	United Church of Christ	Cleveland	OH
Rabbi	Sue	Elwell	Union of American Hebrew Congregations	Philadelphia	PA
Ms.	Marjorie	Enseki	FCC	Eugene	OR
Rabbi	Rachel	Esserman		Endwell	NY
Rev.	Jon M.	Fancher	Rocky River Presbyterian Church	Rocky River	OH
Rev.	Douglas E.	Fauth	The Christian Association at the University of Pennsylvania.	Philadelphia	PA

Title	First and Middle Name	Last Name	Organization/Affiliation	City	State
Rabbi	Morley T.	Feinstein	Temple Beth-El	South Bend	IN
Rabbi	Steven M.	Fink	Temple Oheb Shalom	Baltimore	MD
Rev.	Wendy	Fish	First Unitarian Universalist Church	Columbus	OH
Rev.	John W.	Fisher	Sunnyside United Methodist Church	Kalamazoo	MI
Pastor	Eric	Fjeldal	Yalesville United Methodist Church	Wallingford	CT
Rev.	Ray	Flachmeier	Evangelical Lutheran Church of America	Richardson	TX
Rev.	Madonna	Flanders	Alton UMC	Bangor	ME
Rev.	Ann	Fontaine	Episcopal Church	Jackson	WY
Ms.	Rita	Fossell	Presbysterian Women-Churchwide	Lake Bluff	IL
Rev. Dr.	Garnett E.	Foster	Louisville Presbyterian Theological Seminary	Louisville	KY
Rev.	C.H.	Fotch	St. John's Episcopal Church	Ross	CA
Rev.	Kimberly Buechner.	Fouse	Presbyterian Church (USA)	Cold Spring	KY
Rev. Dr.	Richard E.	Fouse	Doylestown Presbyterian Church	Doylestown	PA
Rev.	Anne C.	Fowler	St. John's Episcopal Church	Jamaica Plain	MA
Rev.	Amy A.	Freedman	Channing Memorial Church	Newport	RI
Rabbi	Allen I.	Freehling	University Synagogue	Los Angeles	CA
Rabbi	Gordon M.	Freeman	Congregation B'nai Shalom	Walnut Creek	CA
Rabbi	Jonathan B.	Freirich	Cleveland Hillel	Cleveland	OH
Rabbi	Ronne	Friedman	Temple Israel	Boston	MA
Rabbi	Alan D.	Fuchs		White River Junction.	VT
Rev.	Holly Spencer.	Fuqua		Lexington	KY
Rev. Dr.	George T.	Gardner	College Hill United Methodist Church	Wichita	KS
Rabbi	David J.	Gelfand	The Jewish Center of the Hamptons	East Hampton	NY
Rev.	Gretchen Seidler.	Gibbs		Mill Creek	IN
Rev.	Gordon D.	Gibson	Unitarian Universalist Fellowship of Elkhart	Elkhart	IN
Rev.	Lance A.B.	Gifford	St. John's Mt. Washington	Baltimore	MD
Rev.	Martha E.	Gilbert	The United Methodist Church	Ellenburg	NY
Rev.	Richard S.	Gilbert	First Unitarian Church	Rochester	NY
Rev.	Christopher A..	Gilmore	Winnetka Congregational Church	Winnetka	IL
Rabbi	Gail	Glicksman		Haverford	PA
Rabbi	Brian	Glusman		Birmingham	AL
Rev.	Jerry	Goddard	Unitarian Universalist	Newmarket	NH
Rabbi	Irwin	Goldenberg	Temple Beth Israel	York	PA
Rabbi	Jeffrey W.	Goldwasser	Congregation Beth Israel	North Adams	MA
Rev.	Thomas W.	Goodhue	United Methodist Church of Bayshore	Bayshore	NY
Rev.	Charlotte	Gosselink	PA Southeast Conference UCC	Collegeville	PA
Rev.	Beth	Graham	Unitarian Universalist Fellowship	Huntington	NY
Rev.	Peter	Grandy	Asylum Hill Congregational Church	Hartford	CT
Rev.	Robert J.	Granger	Overlook United Methodist Church	Woodstock	NY
Cantor	Oma T.	Green	American Conference of Cantors	Teaneck	NJ
Rev. Dr.	W. Bradford	Greeley	Main Line Unitarian Church	New Castle	NH
Rabbi	Frederick	Greene	Congregation B'nai Israel	Bridgeport	CT
Rev. Dr.	Larry	Greenfield	Religious Institute for Sexual Morality, Justice and Healing.	Chicago	IL
Rev.	John M.	Gregory-Davis	Meriden Congregational Church, UCC	Meriden	NH
Rev.	Susan	Gregory-Davis	Meriden Congregational Church, UCC	Meriden	NH
Rev.	Daphne	Grimes	Episcopal Church	Cody	WY
Rev. Dr.	Larry A.	Grimm	St. Paul Presbyterian Church	Lakewood	CO
Rev. Dr.	J. Bennett	Guess	Justice and Witness Ministries, UCC	Cleveland	OH
Ms.	Debra W.	Haffner	Religious Institute on Sexual Morality, Justice, and Healing.	Norwalk	CT
Rev.	Bill	Hamilton-Holway.	Unitarian Universalist Church of Berkeley	Berkeley	CA
Rev.	Barbara	Hamilton-Holway.	Unitarian Universalist Church of Berkeley	Berkeley	CA
Rev.	Barbra M.	Hansson	Unitarian Universalist	Plattsburgh	NY
Rev.	Charles E.	Harlow	UCC	Talent	OR
Rev.	Cedric A.	Harmon		Washington	DC
Rev. Dr.	Marni	Harmony	First Unitarian Church	Orlando	FL
Rev.	Allen V.	Harris	Franklin Circle Christian Church (Disciples of Christ).	Cleveland	OH

Title	First and Middle Name	Last Name	Organization/Affiliation	City	State
Ms.	Sandra	Harwood	First Presbyterian Church-Buffalo	Buffalo	NY
Rev.	Danna Drum	Hastings			
Rev.	Kathryn	Hawbaker		Camden	OH
Rev.	Ann L.	Hayman	Mary Magdalene Project	Reseda	CA
Rev.	Barbara A.	Heck	Rutgers Protestant Campus Ministries	New Brunswick	NJ
Rev.	Jane	Heckles	So. Cal. Nev. Conference, United Church of Christ.	Altadena	CA
Rev. Dr.	Joel J.	Heim	Disciples Peace Fellowship	Waukesha	WI
Rev.	Ken	Henry	Central Presbyterian Church	Eugene	OR
Rev.	Kathleen	Hepler	Unitarian Universalist Congregation of Monmouth County.	Lincroft	NJ
Rabbi	Rachel	Hertzman	Hillel of Greater Baltimore	Baltimore	MD
Rev.	Jean Ellen	Herzegh	PC (USA)	Burns	OR
Rev.	Anita C.	Hill	St. Paul Reformation Lutheran Church	St. Paul	MN
Ms.	Bani	Hines-Hudson	Director of Education-PP of Greater Louisville	Louisville	KY
Rev.	Allen	Hinman	St. John's Episcopal	Passaic	NJ
Rev.	Elaine	Hinnant	First Plymouth Congregational, UCC	Englewood	CO
Rev.	Virginia C.	Hoch	Goshen United Methodist Church	Goshen	NY
Rev.	Linda	Hoddy	Unitarian Universalist Congregation	Saratoga Springs	NY
Rev.	Judith M.	Hoffhine	Broad St. Presbyterian Church	Columbus	OH
Rev.	David J.	Holden	United Church of Christ	Cleveland	OH
Rev.	Mark R.	Holland	Trinity UMC	Kansas City	KS
Rev.	George E.	Hollingshead		Villanova	PA
Rev.	Charles F.	Holm	First Presbyterian Church	Easton	PA
Rev.	Jean A.F.	Holmes	Nauraushaun Presbyterian Church	Pearl River	NY
Mr.	Joseph C.	Hough, Jr.	Union Theological Seminary	New York	NY
Rev.	D. Scott	Howell	United Church of Christ	Cleveland	OH
Rev.	Magaret E.	Howland	White Plains Presbyterian Church	White Plains	NY
Dr.	Mary E.	Hunt	Women's Alliance for Theology, Ethics and Ritual (WATER).	Silver Spring	MA
Rev. Dr.	Robert D.	Hurlbut		St. Paul	MN
Deacon	Nancy W.	Huston	Episcopal Church	Omaha	NE
Ms.	Betty	Huthcheson		Buffalo	NY
Rev.	Randy	Hyvonen	Washington, North Idaho Conference, UCC	Spokane	WA
Rev.	Michael B.	Ide	Evangelical Lutheran Church in America	St. Louis	MO
Rev.	William	Ingraham	Church of the Good Shepard	Anne Arbor	MI
Rabbi	Lisa	Izes	Temple Sinai	Rochester	NY
Rabbi	Andrew	Jacobs	Bet Am Shalom Synagogue	White Plains	NY
Rabbi	Cheryl	Jacobs	Planned Parenthood Hudson Peconic	Hawthorne	NY
Pastor	Alexander M.	Jacobs	Lutheran Campus Ministry	Milwaukee	WI
Rev.	B. Leslie	James	Macedonia African Methodist Episcopal Church	Seaford	DE
Rev. Dr.	Mark	Jennings	First Presbyterian Church	Richland	MI
Rev.	Madeline	Jervis	Clarendon Presbyterian Church	Arlington	VA
Rev.	Bryan T.	Jessup	The Unitarian Universalist Church of Fresno	Fresno	CA
Rabbi	Daniel	Jezer	Congregation Beth Sholom-Chevra Shas	De Witt	NY
Board Chair.	Ann Hale	Johnson	Union Theological Seminary, NYC	Potomac	MD
Rev.	Bruce	Johnson	Unitarian Universalist Church of Indianapolis	Indianapolis	IN
Rev. Dr.	William R.	Johnson	Wider Church Ministries, United Church of Christ	Cleveland	OH
Ms.	Janet	Johnson		Concord	CA
Rev.	Kathryn	Johnson		Seattle	WA
Rev. Dr.	Peggy	Johnson	United Church of Christ	Santa Barbara	CA
Rev.	Anthony P.	Johnson	First Unitarian Universalist Church of Essex County.	Orange	NJ
Rev.	Rebecca	Johnston	Our Savior's United Church of Christ	Ripon	WI
Rev.	Charles H.	Jorday	Pleasant Run UCC	Indianapolis	IN
Ms.	Kathleen	Kahl		Chilton	WI
Rabbi	Mark	Kaiserman	Temple Emanu-El	Dalllas	TX
Rabbi	Jeremy	Kalmanofsky	Congregation Ansche Chesed	New York	NY
Rabbi	Lewis	Kamrass		Cincinnati	OH
Rabbi	Gerald M.	Kane	Temple Beth El	Las Cruces	NM
Rev.	Charles G.	Kast	Community Church of Chapel Hill	Chapel Hill	NC
Rabbi	Nancy	Kasten		Dallas	TX
Rabbi	Alan J.	Katz	Temple Sinai	Rochester	NY
Rev.	Fred	Keip	Unitarian Universalist	Grants Pass	OR

Title	First and Middle Name	Last Name	Organization/Affiliation	City	State
Rabbi	Jonathan	Kendall	Temple Beit Hayam	Stuart	FL
Rev. Dr.	Andrew C.	Kennedy	First Unitarian Society of Milwaukee	Milwaukee	WI
Rev.	Diane	Kenney	United Ministry at USC	Los Angeles	CA
Rev.	Thomas A.	Kerr, Jr	Immanuel Church, Highlands (Episcopal)	Wilmington	DE
Mr.	Amos	Kharma	Metropolitan Community Church of the Spirit	Harrisburg	PA
Ms.	Katharine	Kilpatric	Presbytery of Giddings Lovejoy	St. Louis	MO
Mr.	Steven F.	Kindle	Clergy United, Inc.	Santa Barbara	CA
Rev.	Ruth L.	Kirk	St. Peter's Church, Glenside	Glenside	PA
Rev. Dr.	Ron D.	Kitterman	UMC	Fort Dodge	IA]
Dr.	Joel T.	Klein		Manchester	NH
Rabbi	Elliott	Kleinman		Cleveland	OH
Rev.	David	Knox		Plainfield	IN
Rev.	Tricia Dykers	Koenig		Cleveland Heights	OH
Rabbi	Neil	Kominsky	Temple Emanuel of the Merrimack Valley	Lowell	MA
Rabbi	Sandford	Kopnick	The Valley Temple	Cincinnati	OH
Rabbi	Elisa	Koppel	The Community Synagogue	Port Washington	NY
Rabbi	Douglas E.	Krantz	Congregation B'nai Yisrael	Armonk	NY
Rev.	Daniel H.	Kuhn, Jr.	Vine Street Christian Church	Nashville	TN
Rev. Dr.	Mary	Kuhns		Louisville	KY
Rev.	Wallace Ryan.	Kuroiwa	United Church of Christ	Cleveland	OH
Rabbi	Steven	Kushner	Temple Ner Tamid	Bloomfield	NJ
Rev.	Peter	Laarman	Judson Memorial Church	New York	NY
Rabbi	Howard	Laibson	Temple Israel	Long Beach	CA
Rev.	Jeffrey	Lamb	Unitarian Universalist Church	Midland	TX
Rev.	Werner	Lange	Auburn Community Church	Chagrin Falls	OH
Dr.	Edwin	Lasbury	UMC	Hockessin	DE
Rev.	Debra	Latture	Presbyterian Church (U.S.A.)	Snow Hill	MD
Rabbi	Michael A.	Latz	Temple B'nai Torah	Bellevue	WA
Rev.	R. Vincent	Lavieri	American Apostolic Catholic Church	Greenville	MI
Rev.	Clifford M.	Lawrence Jr.	United Church of Christ	Clearwater	FL
Rev.	Katherine M.	Lehman	St. Bede's Episcopal Church	Menlo Park	CA
Rev.	Lois Robinson.	Lehman	Pitts Creek and Beaver Dam Presbyterian Churches.	Pocomoke City	MD
Rev.	Susan	Leo	Bridgeport United Church of Christ	Portland	OR
Rev.	William	Levering	Summit Presbyterian Church	Philadelphia	PA
Rabbi	Amy	Levin	Congregation B'nai Israel	Gainesville	FL
Mr.	Harry H.	Levy	Temple Beth-El	San Antonio	TX
Rabbi	Eugene H.	Levy	Congregational B'nai Israel	Little Rock	AK
Rabbi	Janet	Liss		Glen Cove	NY
Rabbi	Mark G.	Loeb	Beth El Congregation	Baltimore	MD
Rabbi	Robert H.	Loewy		Metaire	LA
Rabbi	Alan David	Londy	Temple Beth Shalom	Smithtown	NY
Rev.	Daniel M.	Long	Lutheran Church	Lancaster	PA
Rev.	David	Lorenzen	First United Church of Christ	Tipton	IA
Rabbi	Steven Stark	Lowenstein	Temple Sholom of Chicago	Chicago	IL
Rev. Dr.	Doyle A.	Luckenbaugh	UCC	Massillon	OH
Rev.	Douglas	Maben	Green Mountain Presbyterian Church	Lakewood	CO
Rev.	W. Stewart	MacColl	Northwoods Presbyterian Church	Houston	TX
Rev.	Gene	Mace	United Methodist	West Peoria	IL
Rev.	Vilma M.	Machin-Vazquez.	United Church of Christ	Cleveland	OH
Rabbi	Dana	Magat	Temple Emanu-El	San Jose	CA
Rev.	Robert J.	Magliula	Christ the King Church	Stone Ridge	NY
Dr.	Daniel	Maguire	Prof. Of Moral Theology, Marquette University	Milwaukee	WI
Rev.	Lea A.	Mahan	United Methodist Church	Peninsula	OH
Rabbi	Jonathan	Malamy	B'nai Vail Congregation	Vail	CO
Cantor	Bruce	Malin	American Conference of Cantors	Marstons Mills	MA
Rev.	Ron	Manclaw	HIV/AIDS Pastoral Care Network	Fort Lauderdale	FL
Rabbi	Rosalin	Mandelberg	Baltimore Hebrew Congregation	Baltimore	MD
Rev.	Francis	Manly	Unitarian Universalist	Buffalo	NY
Rabbi	Jeffrey M.	Marker		Brooklyn	NY
Ms.	Doriene D.	Marshall	Director of Christian Education, Cottonwood Presbyterian Church.	Salt Lake City	UT
Rev.	Christopher S..	Martin	St. Mary's Episcopal Church	Green Cove Springs.	FL

Title	First and Middle Name	Last Name	Organization/Affiliation	City	State
Dr.	Allen	Maruyama	Heritage Presbyterian Church	Olathe	KS
Rev.	James S.	Massie, Jr.	The Episcopal Church	Olcott	NY
Rev.	Stephen J.	Mather	Member, PPFA Board of Directors	Anaheim	CA
Mr.	Neal	Matson	Church of Christ	Fairbanks	AK
Rev.	Nancy H.	McCarthy	Episcopal Church	Delray Beach	FL
Rev. Dr.	James	McDonald		Washington	DC
Rev. Dr.	Elizabeth	McDonald		Washington	DC
Rev.	Timothy	McDonald	First Iconium Baptist Church	Atlanta	GA
Rev.	David	McFarlane	The Presbyterian Church, Sewickley	Sewickley	PA
Rev.	Deborah A.	McKinley	Third, Scots and Mariners Presbyterian Church	Philadelphia	PA
Rev.	Bethany	McLemore	Pastoral Counseling Center	Roanoke	VA
Rev.	Laurie A.	McNeill	Glenwood Landing	NY.	
Ms.	Carolyn	Meagher	First Congregational Church	Indianapolis	IN
Rabbi	Batsheva	Meiri	Temple Emanuel	Reisterstown	MD
Rev.	Sarah J.	Melcher	Presbytery of Cincinnati	Cincinnati	OH
Rev. Dr.	Robert H.	Meneilly		Prairie View	KS
Rev.	David W.	Meredith	Broad St. United Methodist Church	Columbus	OH
Rabbi	Andrea	Merow	Temple Sholom	Philadelphia	PA
Rabbi	Barbara	Metzinger		Beaumont	TX
Rabbi	James R.	Michaels	Congregation Beth Israel	Flint	MI
Rabbi	Mathew D.	Michaels	Congregation Jewish Community North	Spring	TX
Rev.	Gary L.	Miller		Hartford	CT
Rev.	William P.	Miller	United Methodist Church	Whittier	CA
Rabbi	Rachel L.	Miller	Congregation B'nai Shalom	Walnut Creek	CA
Rev.	Pamela M.	Miller	Episcopal Church	Big Rapids	MI
Rabbi	Jonathan	Miller	Temple Emanu-El	Birmingham	AL
Rev.	Melanie	Miller	First Congregational Church	Chappaqua	NY
Rev.	Joel	Miller	Unitarian Universalist Church	Buffalo	NY
Rev.	Charles S.	Milligan	Prof. Emeritus, Iliff School of Theology	Denver	CO
Rev.	Linda Penrod.	Million	United Methodist Church	Louisville	KY
Rev.	Margaret	Mills	West Reserve Assoc., UCC	Cleveland	OH
Rev.	Susan A.	Minasian	Disciples United Community Church	Lancaster	PA
Rev.	Irene K.	Mitchell		Spokane	WA
Cantor	Alberto	Mizrahi	Anshe Emet Synagogue	Chicago	IL
Rabbi	Jack	Moline	Agudas Achim Congregation	Alexandria	VA
Rabbi	Diana	Monheit	The Temple	Atlanta	GA
Rev.	Karen A.	Monk	United Methodist Church	Kingston	NY
Rev.	Kenneth	Moore	Christian Church in Nebraska	Lincoln	NE
Rev.	Rob	Moore	Evangelical Lutheran Church of America	Houston	TX
Rev.	Mary Katherine.	Morn	First Unitarian Universalist Church	Nashville	TN
Ms.	SarahLee	Morris	Covenant Presbyterian Church	Lubbock	TX
Rabbi	Joel	Mosbacher	Beth Haverim Congregation	MahwahN	J
Pastor	R.W.W.	Mueckenheim	United Methodist Church of Hempstead	Hempstead	NY
Rev.	Martha L.	Munson	Unitarian Universalist Church of East Aurora	Elba	NY
Rev.	John A.	Nelson	The Dover Church	Dover	MA
Rev.	Culver H.	Nelson	Church of the Beatitudes (UCC)	Phoenix	AZ
Rev.	Gustav	Nelson	Presbytery of Des Moines	Des Moines	IA
Rev.	Stacey	Nicholas	Immanuel UMC	Canton	MO
Rev.	Johanna	Nichols	Champlain Valley Unitarian Universalist Society	Middlebury	VT
Rev.	Sala	Nolan	United Church of Christ	Cleveland	OH
Rev.	Eileen	Norrington	United Church of Christ	Cleveland	OH
Mr.	Robert	Ohl	Old York Road Temple-Beth Am	Abington	PA
Rev.	C. Bunny	Oliver	First Presbyterian Church	Ashland	OR
Rev.	Erick	Olsen	First Church Congregational	Fairfield	CT
Rev.	Melanie	Oommen	First Congregational UCC	Eugene	OR
Rabbi	Michael	Oppenheimer	Suburban Temple-Kol Ami	Beachwood	OH
Rev.	Charles Blustein.	Ortman	Unitarian Church	Montclair	NJ
Rev.	Marilyn	Pagan		Chicago	IL
Rev.	Archie M.	Palmer Jr.	Episcopal Diocese of Newark	Glen Ridge	NJ
Rev.	Ann	Palmerton	Broad Street Presbyterian Church	Columbus	OH
Rev.	Sandra	Paran	Hospice of MI	Detroit	MI
Rev.	Richard S.	Parker	United Methodist Church	Babylon	NY

Title	First and Middle Name	Last Name	Organization/Affiliation	City	State
Rev.	R. Wayne	Parrish	Loveland Presbyterian Church	Loveland	OH
Rev.	Stephen J.	Patterson	Theological Seminary	St. Louis	MO
Rev. Dr.	Sheron	Patterson	St. Paul United Methodist Church	Dallas	TX
Rev.	Mark R.	Pawlowski	Planned Parenthood of South Central Michigan	Kalamazoo	MI
Rev.	Ron R.	Payson	Unitarian Universalist	Worcester	MA
Rev.	Edgar	Peara	Unitarian Universalist	Eugene	OR
Rev.	Frederic	Pease	UCC	Dresden	ME
Rev.	Guy R.	Peek	RCRC, Western New York	Niagara Falls	NY
Rev. Dr.	John C.	Peiper	St. Christopher Episcopal Church	Linthicum Heights	MD
Rev.	Barbara	Pekich		Grand Rapids	MI
Rev.	Clare L.	Petersberger	Towson Unitarian Universalist Church	Lutherville	MD
Rev.	Kerri	Peterson-Davis	Presbyterian Church (USA)	Duluth	GA
Rev.	Thomas	Philipp	Long Island United Campus Ministries	Merrick	NY
Rev.	Jeffrey	Phillips	Community United Church of Christ	Champaign	IL
Rev.	John B.	Pierce	Westminster Presbyterian Church	Eugene	OR
Rev.	Deborah	Pitney	First UMC	Eugene	OR
Rev.	Gayland	Pool		Fort Worth	TX
Rev.	Lois M.	Powell	United Church of Christ	Cleveland	OH
Bishop	Neff	Powell	Episcopal Diocese of Southwestern Virginia	Roanoke	VA
Rabbi	Sally J.	Priesand	Monmouth Reform Temple	Tinton Falls	NJ
Rabbi	James	Prosnit	Congregation B'nai Israel	Bridgeport	CT
Rev.	Stephen D.	Quill	New Hope Lutheran Church	Missouri City	TX
Ms.	Marlene	Quinn	Limestone Presbyterian Church	Wilmington	DE
Rev.	Jennifer L.	Rake-Marona	Group Health Cooperative	Tacoma	WA
Rev.	James C.	Ransom	Trinity Episcopal Church	Towson	MD
Rev.	Anita	Rayburn	Tod Ave UMC	Warren	OH
Ms.	Anita	Redding	UCC	Cleveland	OH
Rev.	Willard T.	Reece	Kansas Religious Leaders for Choice	Wichita	KS
Rev.	George F.	Regas	The Regas Institute	Pasadena	CA
Rev.	Nelson R.	Reppert	University United Methodist Church	Syracuse	NY
Rev.	Ernesto	Reyes	UCC	Los Angeles	CA
Ms.	Marlene	Richardson		Greenville	PA
Rabbi	Leah	Richman	Oheb Zedeck Synagogue Center	Pottsville	PA
Rev.	Tim	Riss	United Methodist Church	Smithtown	NY
Rev.	Paul B.	Robinson	Medford Congregational UCC	Medford	OR
Rev.	T. Michael	Rock	Central, United Church of Christ	Providence	RI
Mr.	Dave	Rockafellow	Unitarian Universal Fellowship of Bozeman	Bozeman	MT
Mrs.	Rachel	Rockafellow	Unitarian Universal Fellowship of Bozeman	Bozeman	MT
Ms.	Judith E.	Rogers	Unitarian Universalist Church at Washington Crossing.	Titusville	NJ
Rev.	Cally	Rogers-Witte	Southwest Conference, United Church of Christ	Phoenix	AZ
Rabbi	Liz	Rolle	Temple Sinai	Stamford	CT
Rev.	Brooke	Rolston	Campus Christian Ministry	Seattle	WA
Mr.	Gary	Rooney	Presbyterian Women Churchwide Coordinating Team.	Minneola	KS
Rev. Dr.	Dan	Rosemergy	Brookmeade Congregational Church, UCC	Nashville	TN
Rabbi	Tracee L.	Rosen	Valley Beth Shalom	Encino	CA
Ms.	Ellen Y.	Rosenberg	Women of Reform Judaism, The Federation of Temple Sisterhoods.	New York	NY
Rabbi	David	Rosenn	The Jewish Service Corps	New York	NY
Bishop	Catherine S.	Roskam		Dobbs Ferry	NY
Rev.	Eugene	Ross	Central Pacific Conference—UMC	Portland	OR
Ms.	Gloria	Rothhaas	Lakewood Congregational Church	Lakewood	OH
Rev.	Richard F.	Rouquie, Jr.	Hillwood Presbyterian Church	Nashville	TN
Cantor	Lori	Salzman	Temple Beth Shalom	Needham	MA
Rev.	David	Sammons	Mt. Diablo Unitarian Universalist Church	Walnut Creek	CA
Rev.	Jason W.	Samuel	Transfiguration Episcopal Church	Lake St. Louis	MO
Rabbi	Marna	Sapowitz	Temple Beth Hatfiloh	Olympia	WA
Rev.	Jill Job	Saxby	Maine Interfaith Council for Reproductive Choices and Unitarian Universalist Association.	Cape Elizabeth	ME
Rev.	Anna Clock	Saxon	Westminster Presbyterian Church	Peoria	IL
Ms.	Marilyn	Scarpa		Newton	PA
Cantor	Hollis Suzanne.	Schachner	Temple Shir Tikva	Wayland	MA

Title	First and Middle Name	Last Name	Organization/Affiliation	City	State
Rev.	James W.	Schaefer	UCC	Decorah	IA
Rev.	Donna	Schaper	Coral Gables Cong. Church	Coral Gables	FL
Cantor	Jodi M.	Schechtman	Temple Beth Am	Framingham	MA
Rabbi	Amy R.	Scheinerman	Beth Shalom Congregation of Carroll County	Taylorsville	MA
Cantor	Robert S.	Scherr	Temple Israel	Natick	MA
Rev. Dr.	Robert	Schiesler	St. Luke's Episcopal Church	Montclair	NJ
Mr.	Brian	Schofield-Bodt	Golden Hill United Methodist Church	Bridgeport	CT
Rev.	Christopher	Schooley	Christians Presbyterian Church	Newark	DE
Rev.	William C.	Schram	Presbyterian Church	Fort Myers	FL
Rev.	Gilbert	Schroerlucke	UM Clergy	Louisville	KY
Rev.	Mike	Schuenemeyer	Diamond Bar Congregational UCC	Diamond Bar	CA
Ms.	Helen	Sears	Churchwide Coordinating Team Presby. Women	Owensboro	KY
Rev.	David	Selzer	Episcopal Church of the Good Sheperd	Buffalo	NY
Rev. Dr.	Robert	Senghas	Unitarian Universalist	Burlington	VT
Cantor	Judith	Seplowin	Temple Beth-El	Providence	RI
Rev.	John S.	Setterlund	Lutheran Church	Champaign	IL
Rev.	Arthur G.	Severance	First Unitarian Universalist Church of San Antonio.	San Antonio	TX
Rev. Dr.	David M.	Seymour	United Church of Christ/Presbyterian Church USA	Tulsa	OK
Rev.	Robert E.	Seymour	American Baptist	Chapel Hill	CA
Rabbi	Richard	Shapiro	Congregation B'nai B'rith	Santa Barbara	CA
Rabbi	Alan	Shavit-Lonstein.	Tri-City Jewish Center	Rock Island	IL
Rabbi	Randy	Sheinberg	Congregation Rodeph Sholom	New York	NY
Ms.	Patricia	Shepherd		Des Moines	IA
Rabbi	Alan	Sherman		West Palm Beach	FL
Rev.	Mary E.	Shields	Trinity Lutheran Seminary	Columbus	OH
Rev.	Martha M.	Shiverick	Presbytery of the Western Reserve	Cleveland	OH
Cantor	Linda	Shivers	Congregation Neveh Shalom	Portland	OR
Rabbi	Marion	Shulevitz	Rabbinical Assembly	New York	NY
Rabbi	Robert A.	Silvers	Congregation B'nai Israel	Boca Raton	FL
Rev.	Lib Mcgregor	Simmons	University Presbyterian Church	San Antonio	TX
Rev.	Elisabeth K.	Simpson	First Presbyterian Church	Glen Cove	NY
Rev.	William G.	Sinkford	President, Unitarian Universalist Association	Boston	MA
Rabbi	Steven	Sirbu	North Shore Synagogue	Syosset	NY
Rev. Dr.	Joanne	Sizoo	Presbyterian Church USA	Cincinnati	OH
Rev.	Jeremy	Skaggs	Fellowship Congregational Church	Tulsa	OK
Rev.	Angela Maddalone.	Skinner	First Presbyterian Church of Yorktown	Yorktown Heights	NY
Chaplain	Donald	Skinner	Living Enrichment Center	Wilsonville	OR
Rev.	Stanely E.	Skinner	Emmanuel/Friedens Church	Schenectady	NY
Rev.	Joseph Andrew.	Slane	Southminster Presbyterian Church	Birmingham	AL
Rev. Dr.	Michael D.	Smith	First Presbyterian Church	Grinnell	IA
Ms.	Mary Elva	Smith	Presbyterian Church (USA)	Louisville	KY
Rabbi	Ronald B.	Sobel	Congregation Emanu-El of the City of New York	New York	NY
Rev.	Richard	Sparrow	United Church of Christ	Cleveland	OH
Ms.	Kerith	Spencer-Shapiro.	Hebrew Union College-Jewish Institute of Religion.	New York	NY
Rev.	David W.	Spollett	First Church, UCC	Fairfield	CT
Rev.	E. Kyle	St. Claire	St. Philip's Episcopal Church	New Hope	PA
Rev.	Lynn	Stanton-Hoyle	Clifton Presbyterian Church	Clifton	VA
Rabbi	Sonya	Starr	Columbia Jewish Congregation	Columbia	MD
Rev. Dr.	William R.	Stayton	Widener University	Chester	PA
Cantor	Debra	Stein	The Jewish Center of the Hamptons	East Hampton	NY
Rev. Dr.	Elizabeth	Stein	ELCA; New Hope Lutheran Church	Missouri City	TX
Rabbi	Margot	Stein	Jewish Reconstructionist Federation	Elkins Park	PA
Rabbi	Jonathan A.	Stein		New York	NY
Rabbi	David E.	Stern	Temple Emanu-El	Dallas	TX
Cantor	Ellen	Stettner	Stephen Wise Free Synagogue	New York	NY
Rev.	Jerald M.	Stinson	First Congregational Church	Long Beach	CA
Rev.	Nathan L.	Stone	Unitarian Universalist Fellowship of Waco	Waco	TX
Rabbi	Susan B.	Stone	Temple Beth Shalom	Hudson	OH
Rev.	Robert J.	Stout	UMC	Horse Cave	KY

Title	First and Middle Name	Last Name	Organization/Affiliation	City	State
Rabbi	David	Straus	Main Line Reform Temple Beth Elohim	Wynnewood	PA
Rev. Dr.	Charles H.	Straut, Jr.	UMC	Brooklyn	NY
Rev.	Victoria I.	Streiff-Fraser	Unitarian Universalist Congregation of Columbus, In.	Columbus	IN
Rev.	Elwood	Sturtevant	Thomas Jefferson Unitarian Church	Louisville	KY
Cantor	Jodi L.Sufrin	Temple Beth Elohim.	Wellesley	MA.	
Rabbi	Brooks R.	Susman	Temple Shaari Emeth/PPCNJ	Manalapan	NJ
Rev.	Helen	Svoboda-Barber.	Episcopal	Topeka	KS
Rev.	M. Thomas	Swantner		Pana	IL
Rev.	Gail	Tapscott	Unitarian Universalist Church of Ft. Lauderdale	Ft. Launderdale	FL
Rev.	Arch B.	Taylor	Presbyterian Church	Louisville	KY
Rabbi	David H.	Teitelbaum	Board of Rabbis of Northern California	San Francisco	CA
Mr.	Jeffery L.	Termini		Tonawanda	NY
Rev.	Eugene	TeSelle	Vanderbilt Divinity School	Nashville	TN
Rev.	Bob	Thaden	United Congregational Church UCC	Butte	MT
Rev.	Jane	Thickstun	UU Fellowship of Midland, MI	Midland	MI
Rev.	Tim	Tiffany	First Christian Church	Medford	OR
Rev.	George Ayer	Tigh	UMC	Lansdale	PA
Rev.	Edward	Tourangeau	St. John's Episcopal Church	Lafayette	IN
Rev.	Larry E.	Treece	Evansville United Church of Christ	Evansville	WI
Cantor	Louise	Treitman	Temple Beth David	Westwood	MA
Rev.	Thomas R.	Uphaus	United Church of Christ	Clinton	MI
Rev.	David L.	Van Arsdale	First Presbyterian Church	Kalamazoo	MI
Rev.	Doug	Van Doren	Plymouth Congregational UCC	Grand Rapids	MI
Rev.	Jane W.	Van Zandt	Episcopal Diocese of Maryland	Baltimore	MD
Rev.	Ernest F.	VanderKruik	United Methodist Church	Warwick	NY
Rev.	Karen	Vannoy	United Methodist Church	San Antonio	TX
Rev.	Heidi	Vardeman	Macalester Plymouth United Church	St. Paul	MN
Rev.	Jessica	Vazquez	Christian Church (Disciples of Christ)	Indianapolis	IN
Rev.	Ross	Walters	Eureka Christian Church	Eureka	IL
Rev.	Paul Reynolds.	Warren	St. Paul's UCC	Schulenburg	TX
Rev.	Penelope M.	Warren	Episcopal Church	San Francisco	CA
Rev.	Mary Ellen	Waychoff	Macon County Larger Parish-Presbyterian	New Cambria	MO
Rev.	Theodore A.	Webb	Unitarian Universalist	Sacramento	CA
Rev.	Gloria	Weber	Evangelical Lutheran Church of America	St. Louis	MO
Rabbi	Elyse	Wechterman	Congregation Agudas Achim	Attleboro	MA
Rev.	Cynthia D.	Weems	United Methodist Church	Kansas City	KA
Rev.	Victoria	Weinstein	Channing Memorial Church, Unitarian Universalist.	Columbia	MD
Rev.	Lauren M.	Welch	Episcopal Diocese of Maryland	Baltimore	MD
Rev.	Jonathan N.	Weldon	Episcopal Church of the Resurrection	Eugene	OR
Rev.	Clarence E. Ken.	Whitwer	United Church of Christ	Grand Rapids	MI
Rabbi	David S.	Widzer	Temple Shalom of Newton	Newton	MA
Rev.	Bets	Wienecke	Live Oak Unitarian Universalist Congregation	Goleta	CA
Rev.	Susan Anslow.	Williams	RCRC	Jamestown	NY
Rev.	Clark	Wills	Episcopal Church	Seattle	WA
Rev.	Dennis	Winkelback	New York Conference—United Methodist Church	Newburgh	NY
Rev.	Karyn L.	Wiseman	Grandview UMC	Kansas City	KS
Rev. Dr.	J. Philip	Wogaman	Foundry United Methodist Church	Washington	DC
Rev.	William James.	Wood	St. John's Episcopal Church	Wichita	KS
Rev.	Hillary	Wright		Kansas City	MO
Rev.	Michael G.	Young	First Unitarian Church of Honolulu	Honolulu	HI
Rev. Dr.	Robert D.	Young	Presbyterian USA	West Chester	PA
Ms.	Judith D.	Zelson	Temple Beth-El	Northbrook	IL
Rev.	Craig D.	Zimmerman	St. Paul's United Church of Christ	Ringtown	PA

The 1,700-member Central Conference of American Rabbis and the Justice and Witness Ministries of the United Church of Christ have also endorsed this statement.

Mr. BILIRAKIS. Ladies and gentlemen, thank you so very much. It was a great hearing and you made it such and we have learned an awful lot. I trust we can all do the right thing tomorrow.

Thank you. God bless you.

[Whereupon, at 5:22 p.m., the hearing was adjourned.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF THE AMERICAN CIVIL LIBERTIES UNION

I. INTRODUCTION

The American Civil Liberties Union, a nationwide, non-partisan organization with nearly 300,000 members dedicated to protecting the individual liberties and freedoms guaranteed by the Constitution and laws of the United States, respectfully submits this testimony to the House of Representatives Committee on Energy and Commerce regarding abstinence-only-until-marriage education programs. As the Committee considers H.R. 4122, which would reauthorize the abstinence-only-until-marriage education program contained in Section 510 of the Social Security Act through the year 2007, the ACLU urges the Committee to weigh the serious civil liberties and public health concerns posed by these programs.

While the ACLU believes that discussion of abstinence is an important component of any educational program about human sexuality, we oppose programs, such as the one outlined in Section 510, that focus exclusively on abstinence and censor other valuable information that can help young people to make responsible and safe decisions about sexual activity and reproduction. Moreover, in addition to their restrictions on free speech, abstinence-only-until-marriage programs endanger the health of young people, create a hostile environment for lesbian and gay youth, and dangerously entangle the government with religion.

II. ABSTINENCE-ONLY PROGRAMS CONSTITUTE GOVERNMENT-SPONSORED CENSORSHIP.

The current Section 510 language permits federal funds to be used only for programs that have as their "exclusive purpose," teaching the benefits of abstinence. See 42 U.S.C. § 710. In addition, recipients of these funds may not provide a participating adolescent with any other information regarding sexual conduct in the same setting as the abstinence program. Thus, recipients of federal abstinence-only funds operate under a federally imposed gag order that prohibits them from providing information in a funded program on preventing sexually transmitted diseases or pregnancy through the use of recognized methods of contraception, even when they are asked directly for this information by a young person participating in the program. As the Supreme Court said in *Board of Education v. Pico*, 457 U.S. 853, 867 (1982), when addressing censorship in a school context, "We have recognized that the State may not, consistently with the spirit of the First Amendment, contract the spectrum of available knowledge. In keeping with this principle, we have held that in a variety of contexts the Constitution protects the right to receive information and ideas." (citations omitted).

Because more comprehensive sexuality information cannot be provided in a federally funded abstinence-only program, the result of these programs is that teachers are censored and students are denied critical information. Material on contraception, sexually transmitted diseases, and sexual orientation has literally been ripped out of textbooks used in such programs. Some teachers have been disciplined or threatened with lawsuits for speaking frankly in the classroom about matters of sexuality or for answering direct questions from students. The fear of such recrimination chills important speech in our schools. "[T]he First Amendment . . . does not tolerate laws that cast a pall of orthodoxy over the classroom." *Keyishian v. Board of Regents,* 385 U.S.589, 603 (1967).

The Section 510 abstinence-only program thus infringes on constitutional rights of free expression by censoring the transmission of vitally needed information about human sexuality and reproduction. Section 510 not only suppresses a particular viewpoint on sexuality, which is the most egregious form of speech regulation, *cf. Rosenberger v. Rectors & Vistors of the Univ. of Virginia,* 515 U.S. 819, 829 (1995), it suppresses the very information about sexuality that is most critical to teens. Section 510 leaves grantees no choice but to omit any mention of topics such as contraception, abortion, homosexuality, and AIDS or to present these subjects in a nonscientific, inaccurate or incomplete fashion.

II. ABSTINENCE-ONLY PROGRAMS ARE INEFFECTIVE AND ENDANGER YOUNG PEOPLE'S HEALTH.

There is no compelling data that demonstrate that abstinence-only programs funded under Section 510 are effective in helping to delay sexual initiation or in reducing risk-taking behaviors among young people. In fact, the overwhelming weight of evidence suggests that programs that include messages about *both* abstinence *and* contraception are most effective in delaying the onset of sex among young people, reducing the number of sexual partners they have, and in making them better users of contraception when they do become sexually active.

Far from being concerned about "mixed messages," parents support comprehensive sexuality education that includes information about abstinence and about contraception. Studies show that parents want other trained adults to provide accurate and forthright information about sex to their children. *See* Tina Hoff et al., *Sex Education in the Classroom* 30-33 (2000).

Evidence also suggests that the availability of federal abstinence-only dollars is steering schools away from teaching comprehensive sexuality education altogether, even in their non-restricted (i.e. non-federally funded) programs. There are several causes of this phenomenon. First, schools have limited curricular time to devote to sexuality instruction. If they are paid by the federal government to devote that instructional time to abstinence, they are unlikely to set aside additional time for comprehensive sex education. Second, because federal abstinence dollars are matching dollars, state funds for sex education are being diverted into these programs and there is little state funding left for more comprehensive programs. According to one study, as of 1999, one-third of the nation's high schools were promoting abstinence-only education, while excluding information about contraception and safer sex. *See* Adam Sonfield and Rachael Benson Gold, States' Implementation of the Section 510 Abstinence Education Program, FY 1999, 33(4) *Family Planning Perspectives* 166 (2001). Thus, abstinence-only money is reducing the availability of information that young people—many of whom are already sexually active—need to protect their health and to prevent unintended pregnancies.

Abstinence-only programs also undermine efforts to stop the spread of HIV and other sexually transmitted diseases. These programs often provide inaccurate information about the effectiveness of condoms in preventing the transmission of HIV and exaggerate the data on condom failure rates. Such misleading information poses grave risks to young people's health.

IV. ABSTINENCE-ONLY PROGRAMS CREATE A HOSTILE ENVIRONMENT FOR LESBIAN AND GAY TEENS AND POSE PARTICULAR RISKS TO THE HEALTH OF THESE TEENS.

Abstinence-only programs are particularly harmful to lesbian and gay youth. By excluding information about safer sex practices and teaching about sex only in the context of marriage, abstinence-only programs stigmatize gay and lesbian teens and undermine efforts to educate those teens about HIV and STD prevention.

Abstinence-only programs also create a hostile environment for lesbian and gay youth. These programs rely on fear and shame and address same-sex sexuality only as a context for HIV transmission. At least two widely used abstinence-only curricula—"Clue 2000" and "Facing Reality"—are overtly hostile to lesbians and gay men. Moreover, section 510 requires that all federally funded programs teach that "a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity" and that "sexual activity outside the context of marriage is likely to have harmful psychological and physical effects." See 42 U.S.C. § 710. In a society that generally denies gays and lesbians the right to marry, these programs thus essentially reject the idea of sexual intimacy for lesbian and gay youth and even deny their very humanity. Such clear hostility violates the rights of lesbian and gay youth to attend school free of discrimination.

V. ABSTINENCE-ONLY PROGRAMS DANGEROUSLY ENTANGLE THE GOVERNMENT WITH RELIGION.

Many abstinence-only curricula contain religious prescriptions for proper behavior and values, in violation of the First Amendment's guarantee of the separation of church and state. A popular abstinence-only curriculum called "Sex Respect," for example, was originally designed for parochial school use. While it now uses the term "nature" in place of "God," it still has strong religious undertones and cites religious publications as its reference sources.

Although federal guidelines do not permit abstinence-only grant recipients to convey religious messages and to impose religious viewpoints on participants, in practice, many of these programs do precisely that. In one example, a program that re-

ceived federal abstinence-only funds submitted as part of its grant proposal a request for $750 to buy Bibles for each participant in the program and to engrave the participants' names on the Bibles. Another program that received federal abstinence-only funds submitted a sample skit as part of its funding request in which Jesus was a main character and in which the narrator explained that "Christ can forgive any sins in our lives." This is an inappropriate and unnecessary entanglement of government with religion. The rigidity of the federal abstinence-only requirements make it more likely that such entanglement will occur because it skews funding toward more ideological perspectives and away from more medical and scientific perspectives.

VI. CONCLUSION

The ACLU urges the Committee to weigh these serious civil liberties concerns when considering H.R. 4122.

AMERICAN HOSPITAL ASSOCIATION
April 19, 2002

DEAR ENERGY AND COMMERCE COMMITTEE MEMBER:

On behalf of the American Hospital Association (AHA) and our nearly 5,000 member hospitals, health systems, and networks of care, I am writing to express support for two pressing legislative matters that should be included in your mark up of legislation reauthorizing the Temporary Assistance to Needy Families (TANF) program: Medicaid and SCHIP eligibility for legal immigrants and a longer extension of the Transitional Medical Assistance (TMA) program.

AHA supports legislation that would allow states to cover legal immigrants under Medicaid and SCHIP, such as the Immigrant Children's Health Improvement Act (H.R. 1143). It is important that lawfully present pregnant women and children receive health care at the appropriate time, otherwise, they risk developing health complications that could have been prevented. Hospital emergency room services should not be the sole source of health care for poor immigrants. From an economic and health perspective, the benefits of investing in preventive services for these lawfully present persons are well established.

AHA also supports a full extension of Medicaid services for families making their way from welfare to work. There already is wide bipartisan agreement that continued access to health care is a key factor in helping families stay in the workforce. TMA should be extended permanently or for the full period of this reauthorization bill and measures to simplify enrollment and retention of such families should be included.

Thank you for your consideration of these important matters.

Sincerely,

RICK POLLACK
Executive Vice President

PREPARED STATEMENT OF JOHN R. DIGGS, JR.

Ladies and gentlemen of the Committee: With great pleasure we advocate for the reauthorization of Title V for a full five-year period.

I am a board certified Internal Medicine specialist well versed in the literature and clinical aspects of sexually transmitted diseases and unmarried teenage pregnancy.

We have learned that the ability to freely choose is a characteristic that Americans highly value. Until the advent of Title V through the Welfare Reform Act of 1996, Americans had very little choice in the method in which their children were instructed in schools on the issue of sex education.

Finally, the paradigm shifted from sexual know-how to the new emphasis on character development and the renewal of the emphasis on marriage. Finally it was recognized that Title X, devoted to family planning, was unable to bring about a reduction in unmarried teenage pregnancy or STD rates.

While there was never a provision for actually testing the effectiveness of Title X, its budget continued to grow without significant oversight or evidence of efficacy. Not only that but it turns out that most of the indicators of sexual chaos worsened during the unopposed reign of the "comprehensive sex education" school of thought and teaching.

The most reliable STD statistic is that from NHANES regarding the frequency of genital herpes. The findings are remarkable. The series of studies show that the herpes rate climbed at the same time that condom promotion was at full tilt. The sexual revolution had already been established. AIDS had transformed from a phrase meaning "help" to a deadly, big disease with a little name. During the ten-year period between 1980 and 1990, herpes positivity rose by a third. The most recent NHANES study says that fully 20 percent of Americans over the age of 12 are permanently infected with Herpes 2, the causative agent of genital herpes.

Clearly something comprehensive sex education and condom utilization failed to slow the epidemic—**au contraire,** herpes rates increased.

True understanding of the problem was achieved with the release of a document from the National Institutes of Health entitled "Scientific Evidence of Condom Effectiveness in Preventing Transmission of Sexually transmitted Diseases. The conclusions of the panel after extensive literature review were that scientific proof of condom effectiveness in preventing herpes transmission was lacking. However, this ten-month year old report has not had the expected effect of correcting the erroneous information about so-called 'safe sex' that has dominated the educational platform of the last twenty years. The call for consistent condom use rings out in quarters from Planned Parenthood to a variety of other organizations interested in condom promotion. Unfortunately, it is still considered optional to tell the public the simple truth. Despite the dramatic increase in condom usage, the herpes epidemic continues unabated due to the startlingly obvious factor that condoms don't stop herpes transmission.

The case of herpes and lack of condom effectiveness is only one example of the legerdemain that dominates the philosophy of "comprehensive sex education." Even the name itself is a misnomer. The most comprehensive aspect of the education is the complete denial that the cornerstone of the approach—condoms—has been found to be inefficacious, not by abstinence-until-marriage ideologues seeking supporting data from obscure journals, but by distinguished panel of experts who reviewed copious data to reach their conclusions.

Of eight diseases, the panel could only find scientific evidence of condom effectiveness for one and a half. These results should compel wholesale changes in any program that touts itself as comprehensive. Parents, teachers and doctors should be scrambling to apologize to the offspring, students and patients for relying on outdated misinformation. This misinformation leads adolescents across the country to into a false sense of security not seen since the embarking of the Titanic. For decades, youth have been told to protect themselves with condoms. It turns out that such protection is no more effective than a newspaper protecting a fancy hairdo in a monsoon.

For an educational philosophy that calls itself "comprehensive" to leave out this key piece of information is so ironic that one would think it intentionally sarcastic.

Another example is a series of programs that the Centers for Disease Control and Prevention have labeled "Programs That Work." If there ever was a misnomer, this is it. If a program can be firmly classified as working by a scientific organization, then it should decrease teen pregnancy and STD rates significantly and repeatedly. However, that is not the criteria by which these programs were christened. Instead, all they showed was an increase in condom usage and a delay in first sexual experience measured in mere weeks. Having established that condoms have severely limited proof effectiveness, programs that increase condom use actually increase the utilization of a defective methodology. More of something that doesn't work is more failure. The programs should be properly titled, "Programs that wished they worked." Multiply numbers less than one leads to smaller and smaller numbers, not better outcomes.

The CDC admits that 65 million Americans have an incurable sexually transmitted disease. This information, combined with the NIH findings on scientific evidence of condom effectiveness, is an irrefutable indictment of the comprehensive sex methodology. It has not worked and it cannot work. Furthermore, there is no theoretical foundation to expect success of the condom-based protection in the future.

The result has been that we daily expose our youth to incurable disease. Most notable among these is human papilloma virus, HPV. The American Cancer society agrees that HPV is the causative agent of cervical cancer, a malady that kills more women in the USA than AIDS.

The good news is that Health and Human Services, under the guidance of the Welfare Reform Act, invested in a new approach that has several important characteristics that distinguish it from the failed and simplistic "Just Say Condom" campaigns of the last two decades. Not only are the characteristics distinct but also the tone is distinct.

Abstinence-until-marriage education is directive. It does not abandon teens to a panoply of complex choices where the most troublesome choices are also the most attractive. It does what any good teaching does—spotlights the best choice and presents it as the expected selection. Students respond to high expectations better than low common denominators.

Abstinence-until-marriage education is modest. It does not violate the natural modesty of children by having an authority figure direct them to mimic handling mockups of male organs to demonstrate efficiency in handling prophylactics. There are two major problems. First, efficient handling of an inefficient product results in more STD exposure, not less. Second, it is degrading, especially for girls to publicly, in the name of academic education, practice private adult behavior. Condom games in the classroom game trivialize the marital act. While such trivialization is the staple of pornographers and other media exploiters, it degrades the classroom. The classroom should train our youth to compete academically in a hostile world. What can be more embarrassing than to discover that American kids can handle condoms but not the Pythagorean theorem? Such misplaced priorities are a recipe for disaster in terms of national security, national economic status, the ongoing development of superior educational systems and students. The most tragic victim is the national moral standard.

Alex de Tocqueville said two centuries ago that, "America is great because America is good." He did not say, "America is great because their young 'uns can whip on condoms like no one in Europe!"

Abstinence-until-marriage builds character and self-control. Unlike slapping on a condom, self-control must be cultivated over time. It is not a momentary act to master. When properly developed, it will help teens become adults that are effective, resistant to corruption, long-range planners, and considerate of others. On the other hand, condom-focused mentality thinks only of pleasing self. It demands immediate and compulsive satisfaction. Just as self-control bleeds into areas of life other than the sexual, likewise does the practice of immediate gratification.

If society seeks an answer to the upward spiral of sexual assault of children and by children, look no further than the mantra of low expectations pedaled to youth, "Kids are going to have sex anyway." If that notion, confirmed by adults, is accepted by the teens, having sex "anyway" can include even if the other person says "no."

The character building associated with abstinence-until-marriage will benefit other areas of life. Several high-profile financial scandals, cheating at prestigious universities and public officials lying under oath point to the need to reinstate good character as a virtue rather than a stigma.

Slowly but surely, it is becoming common knowledge that it is true: Abstinence-until-marriage and faithfulness within marriage are the only 100 percent effective ways to avoid unmarried parenthood and STDs. Begrudgingly, even abstinence opponents admit this. They were, of course, encouraged to do so because there was a money stream attached to accepting such statements. Indeed, a number of parties affiliated with Planned Parenthood applied for Title V grants despite publicly denigrating the concepts.

Their reluctantly offered endorsement is accepted.

But there is something more important that comes with the Title V authorization. It is something that is usually prized by the most vocal opponents to Title V. That is "choice."

Parents should have a choice of how to educate their children. Ideally, education on these issues should be issues for home and not for school. There has not been much choice in the last two decades. Coarse and graphic treatment of sex has been imposed by those who felt that the crisis was so urgent that we should bypass the usual precautions. Those precautions protect minors from sexual and age-inappropriate images, inappropriate classroom discussion, and degrading and embarrassing classroom demonstrations.

This was done in the name of eliminating a crisis but appears, instead, to have perpetuated a crisis.

Much was made of a decision by the American Medical Association to endorse condom distribution in schools instead of abstinence. The AMA, in that same statement admitted that the decision was not based on the weight of the evidence. They wrote, "condom distribution shows promise." About abstinence they wrote, "needs more study." Each of these phrases mean the same thing—data is lacking to come to a scientific conclusion. Rather than plainly stating that, a small body of a few more than a dozen persons leveraged the entire organization of 350,000 physicians to supposedly support this position. I applaud the honesty of the drafters in not overstating their findings. Indeed, data does not exist to make a scientific conclusion. Therefore, the AMA was reduced to endorsing a position despite a lack data to do so.

An intelligent reading of the AMA's resolution reveals that we still have "choice." Yes, parents and educators can legitimately challenge and even reject the failed comprehensive sex paradigm.

Indeed, they have done so in droves. Hundreds of people and organizations have applied for funding provided by Title V. The government seed money has served to bring hope, modesty and respect to a position that ALL parties admit is the only one with 100 percent success in stopping the STD epidemic and unmarried teenage pregnancy. It only fails when people choose not to use it.

Title V funding has brought about the development of new curricula and programs that bring hope, smiles, dignity and future orientation to a generation that has been hijacked into the existential wasteland of immediate gratification. The new programs serve to offer all teens a better way, a path with clear direction, solid principles and respect for the dignity of the individual. Most of all, important truths are revealed, finally magnifying the fine print of on condom efficiency. The fine print reads "All you have heard about condoms as protection has been greatly exaggerated. More condom usage has only resulted in more STD transmission."

The reauthorization should be for the full five years. I have studied the questionnaire that is expected to offer "the final word" on abstinence-until-marriage. The questionnaire could not possibly answer the question, "Does abstinence-until-marriage work?" It reads more like a sex survey. The most astute parents will not permit their children to answer such invasive questions. The programs that understand the importance that modesty plays in a person maintaining integrity will also reject invasive questions. Therefore, the only persons who will consent are those who have an impaired sense of modesty. This produces selection bias that decreases the validity of such a questionnaire.

The other major problems with this questionnaire are beyond the scope of this testimony but can be obtained by writing the Committee for Sound Evaluation at PO Box 45, South Hadley, MA 01075.

With this tightly woven logical compendium of facts, it is a basic call to "choice" to allow parents and programs to continue the maturing of abstinence-until-marriage as the alternative to disastrous legacy of "comprehensive sex education" and its misnamed clone, "Abstinence Plus."

I offer this testimony with honesty and simplicity, as a physician that diagnoses and treats people who have grown up knowing nothing but "safe sex." If it were truly safe, I would not have to treat them.

Please permit American families to continue to have a choice in this matter. If they don't want it, they can reject it at the state level by not matching the federal funds. Thus far, 49 of 50 states have seen fit to match the federal funds. That speaks volumes.

Authorize Title V Abstinence-until-marriage for another five years. Choice is not dependent upon the results of a seriously flawed evaluation.

PREPARED STATEMENT OF ALMA L. GOLDEN, MEDICAL DIRECTOR AND CAROL J. RAND, SAGE ADVICE COUNCIL, INC.

The casualties of war are many and are strewn all around us. They are not the wounded, maimed and dead of terrorist attacks. They are the cancer-stricken, infertile and mortally wounded of sexually transmitted diseases. Most of their wounds were initially inflicted during adolescence. Deceived into believing that they were fully armed and protected, these youth launched into the fray of the ongoing sexual revolution. However, as P. J. O'Roarke has said, "The germs won.'"

Each year, three million of the STDs contracted occur among adolescents. Consequences of these infections range from quickly curable to lethal. Bacterial infections such as chlamydia and gonorrhea can be cured but, if left untreated in the female adolescent, they lead to pelvic inflammatory disease which scars reproductive organs and greatly increases the probability of infertility. Viral infections such as herpes simplex, human papilloma virus (HPV), and HIV have lifelong and potentially fatal consequences. Eruptions of herpes simplex can be randomly reactivated throughout life, causing not only pain and discomfort to the individual but also the possibility of transmission to the sexual partner. HPV infects about 30% of the sexually active teens, though rates between 45% and 51% have been found among female army recruits. Since HPV is associated with 93% or more of the cases of cervical cancer, and approximately 10% of those infected will progress to dysplasia, health ramifications for the next generation are enormous. Finally, though HIV is the least infectious of these STDs, its transmissibility is increased two to five times by the presence of other STDs. Currently, in developed countries, HIV has almost reached a "chronic illness" status. However, when treatment fails, it is fatal.

Additional casualties of this war come from unintended pregnancies. Lives of adolescents and their offspring are forever changed. Young women who choose to terminate these pregnancies often struggle emotionally with the results of that choice for the rest of their lives. Young women who carry these pregnancies full term encounter a host of difficulties—many ensuing from aborted schooling. (Only 64% of teen mothers complete high school or get a GED as compared to 94% of their female peers who did not give birth.) Lower maternal educational level segues into 80% of teen mothers eventually going onto welfare. Subsequently, the single teen mother's incomplete education and limited job opportunities make her children ten times more likely to be poor than those of a married high school graduate who was at least 20 years old at the birth of her first child.

Surrounded by these walking wounded from the most recent campaigns of the sexual revolution, the commanding officers must analyze the current strategy, evaluate its effectiveness and plan a new assault. For the past thirty years, the strategy has been to advocate condom and contraceptive use as the best protection for naturally risk-taking teens.

Just how well has this plan worked? Have millions of American adolescents marched into the heat of battle (pun intended), believing themselves to be more than adequately defended, only to find themselves shot down by "friendly fire"? Young people across the nation are taught that proper use of condoms will protect them against pregnancies and all STDs. The truth is not so benevolent.

In fact, condoms, even when correctly and consistently used, have a 14% failure rate against pregnancies. When the joint report from NIAID and NIH was released in July 2001, the results of a review of 138 studies were not reassuring. No conclusive evidence could be found for condom effectiveness against any STDs except for up to 85% protection against HIV and for female to male transmission of gonorrhea. Additionally, in January, 1998, this statement appeared in Family Planning Perspectives, "After years of increased condom usage, reports show that STD rates are higher than ever."

Even if condoms had been documented to be completely protective, as many teenagers believe, the reality of adolescent condom use was revealed by the American Academy of Pediatrics Committee on Adolescence in June 2001: "Only 45% of adolescent males report condom use for every act of intercourse," and "condom use actually decreases with age when comparing males age 15-17 with males 18-19." Not only are these young warriors equipped with defective defense weapons, but they don't even use them. (That could be related to the sixteen steps of correct condom use which pediatricians are encouraged to review with their adolescent patients.)

If the previous defense weaponry hasn't worked, what can? Recent legislation, the Welfare Reform Act of 1996, has funded abstinence-only education for adolescents. Though these are relatively recent programs, ten scientific evaluations have been done. All conclude that statistically significant decreases in rates of sexual activity and of teen pregnancy occurred in the communities where these programs were implemented.

Rather than emphasizing the mechanics of sexual intercourse and of proper condom use, these programs stress the importance of strong character and family communication. Through the successful curricula, young people are taught to value fidelity and to resist negative peer pressure. Parents are the essential support personnel which this education brings into the war. Their powerful influence in guiding adolescents toward the healthiest choice (abstinence until marriage) is deliberately sought, rather than excluded. Once adolescents have the necessary skills in building loving, enduring relationships and have the support of their families, they can successfully avoid risk behaviors, such as sexual activity, which can sabotage their mission to become confident, capable and committed adults.

The growing field of abstinence education affords great promise for America's young people—a future of optimal physical health (free of pregnancies and STDs), of optimal emotional health (free of guilt and regret) and of optimal spiritual health (full of a strong character and positive choices). Continued expansion of abstinence-until-marriage programs will also provide sufficient evaluation data to document its effectiveness in protecting adolescents.

There is no need to send more ill-equipped American teenagers into the fierce battles of the sexual revolution. It is time for the commanding officers to assume proper responsibility, choose the most effective strategy and lead their troops to the healthiest possible future.

May 1, 2002

Committee on Energy and Commerce
Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515-6115

DEAR MR. CHAIRMAN: On behalf of The Alan Guttmacher Institute (AGI), a not-for-profit corporation specializing in research, policy analysis, and public education on issues related to sexual and reproductive health, I appreciate the opportunity to submit written testimony for the official record of the hearing held on April 23, 2002, before the Subcommittee on Health of the Energy and Commerce Committee, entitled "Welfare Reform: A Review of Abstinence Education and Transitional Medical Assistance."

In recent years, AGI has conducted extensive research on matters that have a direct bearing on current policy discussions around abstinence promotion and sexuality education. This research includes nationally representative surveys of local public school district superintendents as well as public school teachers in grades 5-6 and 7-12; an analysis of the factors responsible for recent declines in teenage pregnancy; and a cross-country comparison of teenage sexual and reproductive behavior. Much of this research appeared in the peer reviewed journal, *Family Planning Perspectives,* between 1999 and 2001.

More recently, AGI summarized many of the Institute's research findings along with key research findings of other experts in the field in three articles published in *The Guttmacher Report on Public Policy.* These articles, which are attached for inclusion in the record, include: "Sex Education: Politicians, Parents, Teachers and Teens" (February 2001); "Teen Pregnancy: Trends and Lessons Learned," (February 2002); and "Abstinence Promotion and Teen Family Planning: The Misguided Drive for Equal Funding" (February 2002). Several of the research findings summarized in these articles include:

- *Abstinence education is already widely taught in schools across the nation:* Fully half (51%) of school districts with a policy to teach sexuality education require that abstinence be promoted to students *as the preferred option* but also permit discussion of contraception; another third (35%) require that abstinence be taught *as the only option* for unmarried people, while either prohibiting the discussion of contraception altogether or limiting discussion to contraceptive failure rates. Only 14% teach about both abstinence and contraception as part of a broader program designed to prepare adolescents to become sexually healthy adults.
- *Teachers are increasingly providing abstinence-only education in the classroom, but many believe they are not meeting their students' need for information.* The proportion of public school teachers who report that they teach abstinence as the *only* way of preventing pregnancies and sexually transmitted diseases rose dramatically between 1988 and 1999—from 2% to 23%. Despite the fact that more than nine in 10 teachers believe that students should be taught about contraception, one in four say they are instructed not to teach the subject. One in four teachers also say that they believe they are not meeting their students' need for information.
- *The vast majority of American parents favor broader sex education programs over those that teach abstinence exclusively.* Almost two-thirds of parents (65%) believe that sex education should encourage young people to delay sexual activity and also prepare them to use birth control when they do become sexually active. Moreover, among the one-third who say that adolescents should be told "only to have sex when they are married," an overwhelming majority also say that schools should teach adolescents how to use condoms and where to get and how to use other birth control methods.
- *Research shows that more comprehensive sexuality education can be effective in reducing teenage pregnancy and promoting healthy behaviors.* Meta-evaluations of teenage pregnancy prevention programs, including those that teach sexuality education, indicate that programs that discuss both abstinence and contraception can help young people to postpone sexual intercourse, and to reduce the frequency of sex and increase contraceptive use among sexually active teens. In contrast, these meta-evaluations conclude that there is no reliable evidence to date supporting the effectiveness of abstinence-only education.
- *New research is also beginning to show that abstinence-only education and strategies may have harmful health consequences for teens by deterring contraceptive use among those who are sexually active.* The one national study available shows that programs that encourage students to take a virginity pledge promising to abstain from sex until marriage helped delay the initiation of intercourse in some teens, but teens who broke their pledge were one-third less likely than non-pledgers to

use contraceptives once they became sexually active. Similarly, sexually active teens who received abstinence-only messages were found to be less likely to use condoms than those who received safer-sex information designed to reduce the risk for HIV infection.

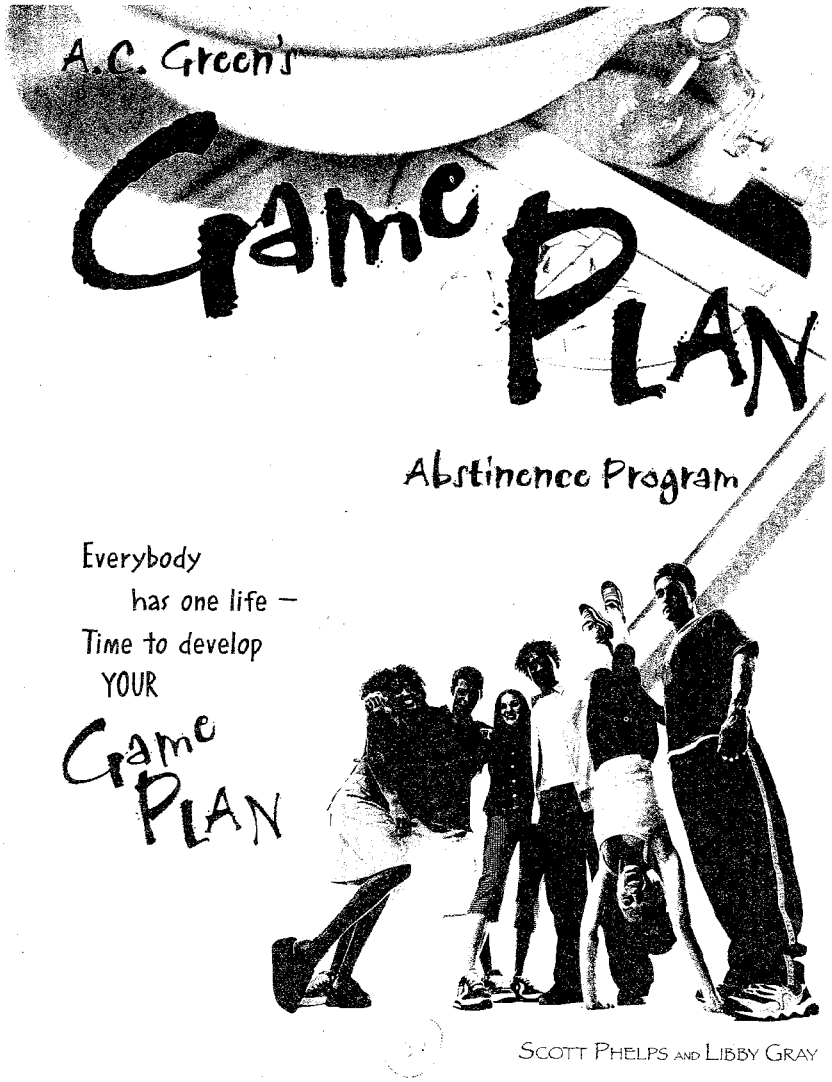
- *Recent declines in teen pregnancy can be attributed to both abstinence and contraception—but in different proportions.* Approximately one-quarter of the decline in teenage pregnancy in this country between 1988 and 1995 was due to increased abstinence, while approximately three-quarters of the drop resulted from improved contraceptive use among sexually active teens. (AGI's methodology follows the consensus of a group that was convened by the National Institute of Child Health and Human Development to examine measurement issues regarding teen sexual activity and contraceptive use, which included researchers from AGI, the National Center for Health Statistics, The Urban Institute, Child Trends and the National Campaign to Prevent Teenage Pregnancy.)
- *Clearer messages about the importance of contraceptive use in other Western industrialized nations contribute to their lower rates of teenage pregnancy.* Teenagers in the United States continue to experience substantially higher pregnancy rates and birthrates than do teens in other Western industrialized countries. This is not because they have higher rates of sexual activity but because they are less likely to use any contraceptive method and especially less likely to use high effective hormonal methods. Moreover, sexuality education and other communication efforts in these other countries clearly and unambiguously stress the importance of contraceptive use for sexually active people who are not actively seeking pregnancy and that childbearing belongs in adulthood.

Based on this information, AGI strongly believes that the restrictive definition of abstinence education contained in PRWORA and reauthorized by H.R. 4122—which requires the exclusive promotion of abstinence and which prohibits any discussion of the value of contraception—ignores what is largely responsible for recent declines in teenage pregnancy, is out of step with the desires of teachers and parents, prevents states from using federal dollars to implement sexuality education programs that have been proven to be effective, and may in fact place young people at risk by denying them the information they need to protect themselves against unintended pregnancy and sexually transmitted diseases. We therefore urge you instead to consider funding proven programs that encourage young people to delay sexual activity while teaching them about the importance and value of contraceptive use for people who are sexually active.

We hope that this research and analysis will prove useful as the House of Representatives considers the reauthorization of section 510. Thank you for the opportunity to present this information and to express our views.

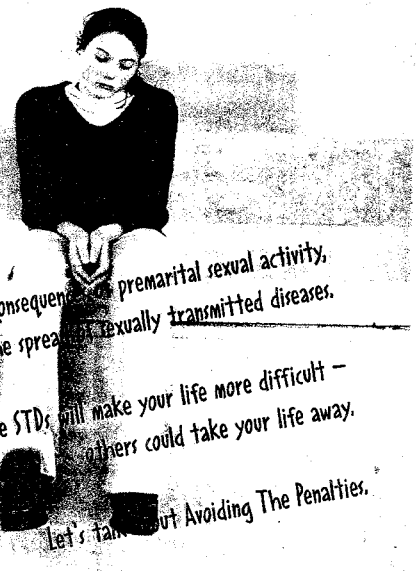
Sincerely,

CORY L. RICHARDS
Senior Vice President, Vice President for Public Policy


A.C. Green's
Game Plan
Abstinence Program
Everybody
has one life –
Time to develop
YOUR
Game Plan
Scott Phelps and Libby Gray

Chapter 4

Avoiding The Penalties



HIGHLIGHTS

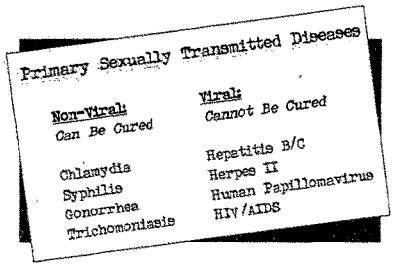
While there are many possible consequences of premarital sexual activity, an increasingly significant problem is the spread of sexually transmitted diseases.

Some STDs will make your life more difficult – others could take your life away.

Let's talk about Avoiding The Penalties.

Avoiding The Penalties

Understanding Sexually Transmitted Diseases



Sexually transmitted diseases (STDs) are primarily bacterial or viral infections which are contracted through sexual activity. Bacterial and other non-viral STDs can be cured with medication. Viral STDs can be medically treated, but they cannot be cured.

STDs are not only contracted through sexual intercourse. Any kind of sexual activity can spread STDs from one person to another.

The U.S. has the highest STD rates of any country in the industrialized world.[1]

1. How many people do you think get an STD each day in America?

   ❑ 4 ❑ 42 ❑ 420 ❑ 4,200 ❑ 42,000

2. Look at the table entitled "Primary Sexually Transmitted Diseases."

   - Which of these 8 diseases do you think is the most common STD in America? _____
   - Which of these STDs do you think is the least common? _____

3. Up until the mid 1970's, there were only two primary STDs: syphilis and gonorrhea. Today, there are over 25 significant STDs with many different strains.[2] What do you suppose accounts for this steep increase in the number and extent of STDs in America?

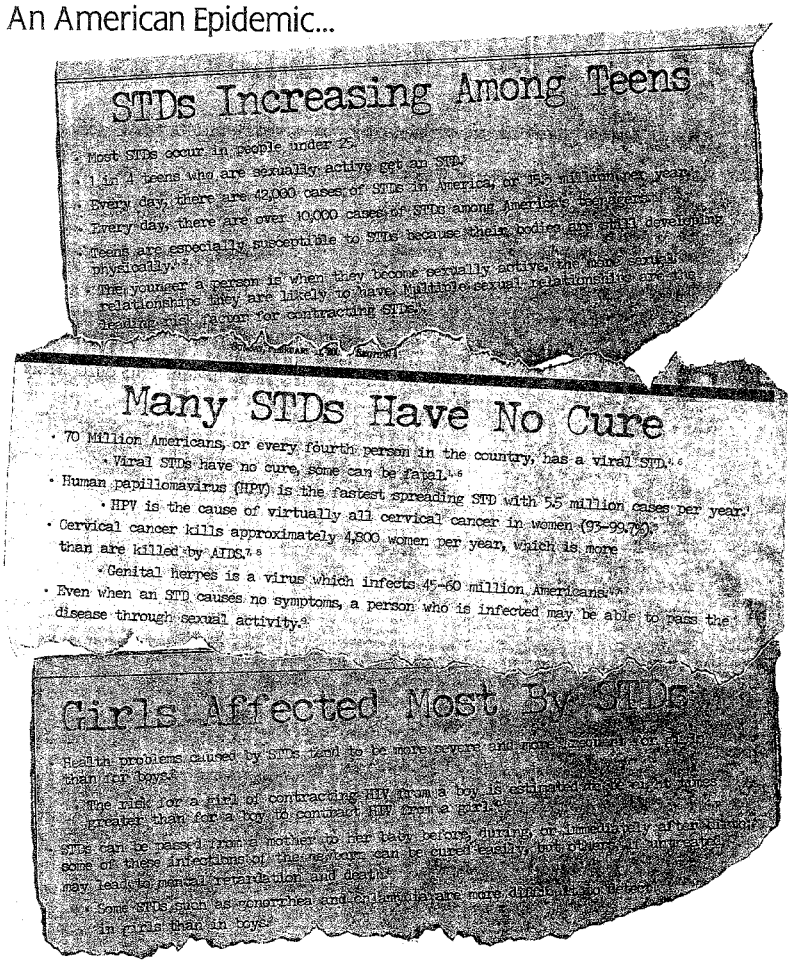
   _____

4. Left untreated, STDs can have serious long-term health consequences, especially for women. Chlamydia and gonorrhea can lead to pelvic inflammatory disease which can cause infertility.[1] Human papillomavirus is the cause of nearly all cervical cancer in women.[3] The risk for these diseases and their consequences is especially high for teens.[4]

   - What is infertility? (If necessary, use a dictionary) _____
   - What is cancer? (If necessary, use a dictionary) _____
   - How could consequences such as these affect a person's future and why is this important to think about?

   _____

An American Epidemic...



STDs Increasing Among Teens

- Most STDs occur in people under 25.
- 1 in 4 teens who are sexually active get an STD.
- Every day, there are 12,000 cases of STDs in America or 4.5 million a year.
- Every day, there are over 10,000 cases of STDs among America's teenagers.
- Teens are especially susceptible to STDs because their bodies are still developing physically.
- The younger a person is when they become sexually active, the more risky relationships they are likely to have. Multiple sexual relationships are a leading risk factor for contracting STDs.

Many STDs Have No Cure

- 70 Million Americans, or every fourth person in the country, has a viral STD.
  - Viral STDs have no cure, some can be fatal.
- Human papillomavirus (HPV) is the fastest spreading STD with 5.5 million cases per year.
  - HPV is the cause of virtually all cervical cancer in women (93-99.7%).
- Cervical cancer kills approximately 4,800 women per year, which is more than are killed by AIDS.
  - Genital herpes is a virus which infects 45-60 million Americans.
- Even when an STD causes no symptoms, a person who is infected may be able to pass the disease through sexual activity.

Girls Affected Most By STDs

- Health problems caused by STDs tend to be more severe and more frequent for girls than for boys.
- The risk for a girl of contracting HIV from a boy is estimated to be [illegible] greater than for a boy to conunact HIV from a girl.
- STDs can be passed from a mother to her baby before, during, or immediately after birth. some of these infections of the newborn can be cured easily, but others, [illegible] may lead to permanent retardation and death.
- Some STDs such as gonorrhea and chlamydia are more difficult to detect in girls than in boys.

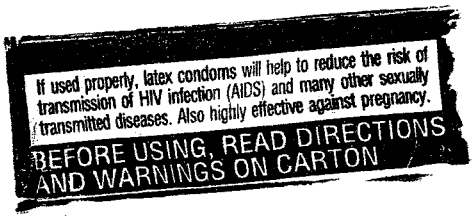
34 Game Plan

Is It Really Safe?

1. It is often claimed that condoms provide "protection" from pregnancy and STDs.

   - Do you think that condoms provide complete "protection" from pregnancy and STDs? ❑ Yes ❑ No ❑ Not Sure
   - If a condom is used is it still possible to become (or to get someone) pregnant? ❑ Yes ❑ No ❑ Not Sure
   - Is it still possible to contract an STD including HIV? ❑ Yes ❑ No ❑ Not Sure

Warning Label On Condom Package: [11]



2. Examine the "Warning Label On Condom Package" inset.

   - Is the word "protection" used on this label? ❑ Yes ❑ No
   - Is the word "risk" used on this label? ❑ Yes ❑ No
   - Bottom line: Notice that the condom company does not claim to provide complete "protection" against either pregnancy or STDs. There is still a "risk" with condoms.

Did You Know?

- **Condoms are not effective** in preventing the spread of HPV, which is the most common STD and has no cure.[12]
  - Some of the most common STDs are contracted from skin to skin contact on areas not covered by a condom.
- Although condom usage has increased significantly over the past 20 years, so has the spread of STDs.[13]
  - While condom usage has increased most among teens, the spread of STDs has also increased most among teens.[13]

Good Play 35

What Do You Think?

1. Look back at the four panels in "Think Ahead" on page 26 and consider the following:

   - Do condoms provide protection from any of the emotional consequences listed? ❑ Yes ❑ No
   - Do condoms provide protection from any of the mental consequences listed? ❑ Yes ❑ No
   - Do condoms provide protection from any of the social consequences listed? ❑ Yes ❑ No

2. Now look at the "physical" panel on page 26, and compare abstinence with condom usage:

	Condoms:		Abstinence:	
• Is there any risk of STDs?	❑ Yes	❑ No	❑ Yes	❑ No
• Is there any risk for infertility from STDs?	❑ Yes	❑ No	❑ Yes	❑ No
• Is there any risk for sexual transmission of HIV/AIDS?	❑ Yes	❑ No	❑ Yes	❑ No

3. If you don't want STDs or any of the other consequences you've listed to happen to you, what would you say is the best way to protect yourself?

36 Good Plan

NON-VIRAL STDs
These Can Be Cured if Properly Diagnosed

Chlamydia: Chlamydia is one of the most common sexually transmitted diseases in the United States today with approximately 3-4 million new cases of infection per year. The highest rates of infection are in teenagers 15 to 19 years old. Because chlamydia usually has no symptoms, it is likely to go untreated. Left untreated in women, chlamydia may cause serious complications including pelvic inflammatory disease in approximately one-third of the cases, which can cause infertility. A pregnant woman may pass the infection to her newborn during delivery, resulting in complications for the newborn.[6]

Gonorrhea: Gonorrhea often has no symptoms. If symptoms of gonorrhea develop, they usually appear within 10 days after sexual contact with an infected person, although in some cases symptoms may develop after several months. Men, who are more likely to have symptoms than women, usually have a thick white discharge and burning sensation during urination and/or painful bowel movements.[6]

"Condoms are hailed today as the answer to sexually transmitted diseases (STDs) and unwanted pregnancies. The facts are, however, that condoms don't always prevent pregnancy and are ineffective against some of the most common, and most serious, STDs, such as Human papillomavirus. Even more widespread than disease are the emotional scarring and deep wounds that come out of broken relationships. No matter how strong a condom is, it won't protect you from a broken heart."

Syphilis: The initial infection causes a painless open sore at the site of infection and then travels throughout the body, causing damage to many different organs over time. The early symptoms of syphilis can be very mild, and many people do not seek treatment when they first become infected. A pregnant woman with syphilis can pass the disease to her unborn child, who may be born with serious mental and physical problems as a result of this infection. Syphilis is highly contagious and can be contracted by any type of sexual contact with an infected person. Although all STDs increase the risk of HIV/AIDS infection, this is especially true of syphilis due to the highly contagious open sores. Left untreated, syphilis can cause fatal damage to the heart and nervous system.[6]

Trichomoniasis: Trichomoniasis, or Trich, is a very common sexually transmitted disease with approximately 3-5 million cases per year in the United States. Trichomoniasis is primarily an infection of the urinary tract and can cause painful urination. Like many other STDs, trichomoniasis may have no symptoms, especially in men. Trichomoniasis is also associated with increased risk of transmission of HIV and may cause a woman to deliver a low-birth-weight or premature infant.[6]

Pelvic Inflammatory Disease: PID is a syndrome or complication of untreated chlamydia or gonorrhea. Each year over 1 million women in the United States develop PID, a serious infection of the reproductive organs. PID can result in scarring of the fallopian tubes which can block the tubes and prevent fertilization from taking place. In some cases, a fertilized egg may become trapped in the fallopian tube causing an ectopic or tubal pregnancy. Although PID is caused by curable bacterial STDs, it can result in permanent damage to the reproductive system if untreated. An estimated 100,000 - 200,000 women each year become infertile as a result of PID.[6]

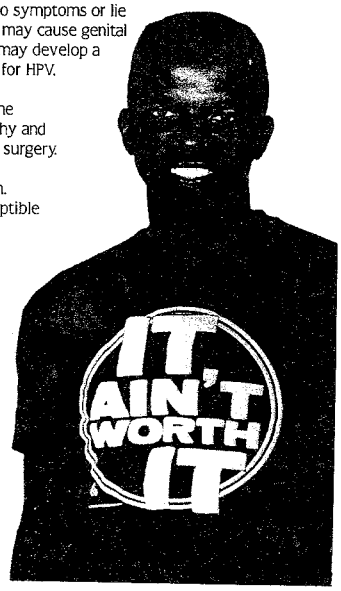
Group Plan 3

VIRAL STDs
These Cannot Be Cured

Genital Herpes (HSV2): Genital herpes affects an estimated 45-60 million Americans. The major symptoms of herpes infection are painful blisters or open sores in the genital area. The herpes sores may disappear within two to three weeks, but the virus remains in the body for life, and the sores may recur from time to time. Medications help control the symptoms but do not remove the virus from the body. Pregnant women with herpes can transmit the virus to their babies. Untreated HSV infection in newborns can result in severe birth defects. There is no cure for herpes.[6]

Human Papillomavirus (HPV): Human papillomavirus (HPV) is the fastest spreading sexually transmitted disease in America today. Approximately 24 million Americans are reportedly infected with a sexually transmitted strain of the virus, and the number continues to grow at a rapid pace of approximately 5.5 million cases per year. Like many STDs, HPV may have no symptoms or lie dormant in the infected person for a number of years. HPV may cause genital warts and/or cervical cancer, although these complications may develop a number of years after the initial infection.[6] There is no cure for HPV.

- **Genital Warts:** Genital warts appear in and around the genital area and are very contagious. Warts can be itchy and uncomfortable and may need to be removed by laser surgery.
- **Cervical Cancer:** Cervical cancer only affects women. The cervix is at the bottom of the uterus and is susceptible to some strains of HPV infection which cause cancer. Cancer may be detected and treated, however, recent statistics indicate that more women die each year from HPV cervical cancer than from AIDS.[7,8]



Hepatitis B/C (HBV/HCV): Hepatitis has three primary strains: A,B,C. Strains B and C can be transmitted through sexual contact. Hepatitis is a virus which targets the liver causing cirrhosis and liver cancer. Approximately 77,000 cases of sexually transmitted hepatitis B infection occur each year in America. There are approximately 750,000 people living with sexually acquired hepatitis B infection. There is no cure for hepatitis B/C.[6]

HIV & AIDS
What's The Difference?

Human Immunodeficiency Virus (HIV) is an incurable retrovirus that attacks the body's T-4 cells. T-4 cells (white blood cells) are central to the body's immune system, which is necessary for the body to fend off various diseases. A healthy body has a T-4 cell count of about 1,200. When HIV reduces the number of T-4 cells to less than 200, the immune system is severely weakened making the body susceptible to a number of diseases. When this occurs, the person is said to have Acquired Immune Deficiency Syndrome (AIDS). There is no cure for HIV.[6]

Acquired Immune Deficiency Syndrome (AIDS) is a condition in which the body's immune system is deficient and therefore is no longer able to defend the body against foreign bacteria, virus, and cancers which overcome the body. This weakened immune system is susceptible to opportunistic diseases (diseases which a healthy body is able to overcome) and eventually results in death. There is no cure for AIDS.[6]

HIV/AIDS is acquired by:
- Sexual contact with an infected partner.
- Blood through a dirty needle used for drugs, or a tainted blood transfusion.
- From an infected mother during pregnancy, or through breastfeeding.

People who have an STD are 2–5 times more likely to contract HIV.[2,4] HIV/AIDS is almost entirely avoidable* by practicing sexual abstinence until marriage, marrying an uninfected partner, and not using drugs.

* It is possible, though unlikely, to acquire HIV/AIDS through a tainted blood transfusion or accidental contact with the blood of an infected person, such as a nurse getting a "needle stick." For most people, these are very remote possibilities. You cannot get AIDS from donating blood.

1 in 3 people who have HIV don't know it.[3]
The only safe sex is in a marriage relationship where a man and a woman are faithful to each other for life.
Don't settle for less than the best. Go for the gold.

Approximately how many people in America do you suppose have a viral, incurable STD?

❑ 70,000 ❑ 700,000 ❑ 7,000,000 ❑ 70,000,000

How many people live in America?

❑ 280,000 ❑ 2,800,000 ❑ 28,000,000 ❑ 280,000,000

Doing the math: (Teacher will instruct) _____ = ____ = ____

Figuring It Out

1. Do you think it would be a good idea to have sex with someone who has an STD?

   _____

2. Do you think it would be a good idea to have sex with someone who has an STD if a condom is used? Why or why not?

   _____

3. How would you know if the person has an STD?

   _____

   - STDs are often asymptomatic, meaning they have no visible symptoms. Why might this be a problem?

   _____

4. What are some ways that getting an STD could effect your future?

   _____

   _____

5. In which of the following categories could STDs effect your future? Check all that apply.

   ❑ Emotional ❑ Mental ❑ Social ❑ Physical

Did You Know?

- Most sexually active teens (70%) have never been tested for STDs.[14]
- In a survey of men who knew they had STDs, approximately 3 out of 4 admitted that they have sex without telling the other person about their STD.[15]
- Any type of sexual activity can and does spread STDs. The only way to be sure of avoiding sexually transmitted diseases is by avoiding all forms of sexual activity before marriage, marrying an uninfected person and being faithful to your spouse.

"When some of my teammates went in for testing of HIV, I didn't go. I knew I was disease free. The way I've chosen is the best way. I've been criticized and ridiculed, but I'm not afraid to stand alone on this issue if I have to. I've seen all the options, and I'm not going to back down."

Sandy's Secret

"I am engaged to be married next year, and I have been diagnosed with genital herpes. I haven't told my fiancé about the herpes and I'm not planning on doing so. My best friend knows about it, and she says that I should tell him. But she doesn't understand how hard it is. I'm afraid to tell him – I can't tell him."

(A true story)

Group Discussion:

What is Sandy's dilemma? Why is she afraid? What do you think will happen if she tells her fiancé about her case of herpes? What do you think will happen if she doesn't tell him? Will he ever find out? Why? How would Sandy's life be different if she had chosen abstinence until marriage? Would she be afraid? What lessons are there for you in this story?

FACT: Most people who have genital herpes don't know it.[16]

Thinking It Over...

Although some STDs are curable, all can have serious physical effects. The best way to avoid the physical and emotional pain that often comes with STDs is to choose abstinence until marriage to an uninfected partner.

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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

APR 23 2002

The Honorable W.J. "Billy" Tauzin
Chairman, Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This is in response to your request for the views of the Department of Health and Human Services on H.R. 4122. Our comments address the bill as introduced.

Section 1 of H.R. 4122 will amend section 510 of the Social Security Act to extend abstinence education funding under the Maternal and Child Health Program through FY 2007. The Administration strongly supports a five-year reauthorization of this program of matching grants to States for abstinence education. Projects funded under this program promote the health and well-being of adolescents by providing them with the critical information that abstinence from sexual activity is the only 100 percent effective way to prevent pregnancy and sexually transmitted diseases.

Section 2 of H.R. 4122 will extend for a year, through FY 2003, the extension of Medicaid eligibility for families in transition from welfare to work. This coverage helps to ensure that work rewards families by preventing them from losing their health coverage when they start jobs. The Administration supports helping families through Transitional Medicaid Assistance, and included the same proposal in the President's FY 2003 budget.

The Office of Management and Budget has advised that there is no objection to the presentation of this report on H.R. 4122 to the Congress, and its enactment would be in accord with the President's program.

Sincerely,

Tommy G. Thompson

The Honorable Michael Bilirakis
Chair, Health Subcommittee
House Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Bilirakis:

The Center for Law and Social Policy (CLASP) appreciates the opportunity to submit this statement for the record of the public hearing "Welfare Reform: A Review of Abstinence Education and Transitional Medical Assistance" held on Tuesday, April 23, 2001. CLASP, a national non-profit organization founded in 1968, conducts research, legal and policy analysis, technical assistance, and advocacy on issues related to economic security for low-income families with children. CLASP is engaged in TANF reauthorization and this includes the full range of issues related to reauthorization and teen pregnancy/reproductive health. In this area we publish analysis on such topics as: TANF spending on teen pregnancy prevention, TANF spending on teen parent services, the TANF teen parent living arrangement and education requirements, the out-of-wedlock bonus, teen marriage, TANF teen parents with disabilities, and "family cap" policies. Our materials are all available free of charge on our web site: www.clasp.org. In this statement, CLASP will focus on reauthorization of the abstinence education program.

The 1996 federal abstinence education program is often misunderstood. In part this is because abstinence education can mean different things to different people. For some, abstinence education means information that asserts one should abstain from sex at every age unless one is married; for others, abstinence education means programs that promote abstinence as the only sure way to avoid pregnancy and sexually transmitted illnesses and that when one stops abstaining it is important to know how to contracept. Many are unaware that the statute defines a program with the former approach, the most restrictive approach -- sometimes called abstinence-unless-married education.

The law's definition of a fundable program has eight points, including that the program teach that "sexual activity outside the context of marriage is likely to have harmful psychological and physical effects" [Attachment A provides the full text of the law]. The program operates through the Maternal and Child Health (MCH) block grant and provides $50 million in federal funds each year to support abstinence programs that preclude education about contraception; a state match of $3 for every $4 federal dollars is required.

The law was enacted without any research base suggesting that a restrictive abstinence approach works at reducing teen pregnancy and births. There still is none. As

noted in a recent review of evaluations of abstinence programs published by the National Campaign to Prevent Teen Pregnancy, "there do not currently exist any abstinence-only programs with reasonably strong evidence that they actually delay the initiation of sex or reduce its frequency." The author used strict criteria in determining what studies of sexuality education programs to include in his review of evaluations; only three such abstinence-only studies met the criteria.[i]

Unfortunately, the federally funded evaluation of abstinence-unless-married programs funded through the 1996 law will not be finalized until 2003; thus, the 2002 reauthorization process will not be able to benefit from any insights offered by the evaluation. While the evaluation should help us learn more about some of the impacts of the programs it will, nevertheless, not answer the question that needs to be asked. That central question is "How does a program of abstinence-unless-married education compare to an abstinence program that also provides contraceptive education?"

There is good reason to compare different types of approaches to abstinence: available research raises concerns about an abstinence education approach that does not provide contraceptive education. At the same time, there is a bit of encouraging news that some abstinence strategies may help delay the onset of sexual activity, particularly among the youngest adolescents. But the abstinence-unless-married approach can backfire when aimed at older teens.

- A comparison of in-school youths who took a "virginity pledge" and those who did not found that some virginity pledgers were at greater risk when they first engaged in sexual intercourse. The pledge—to abstain from sex until marriage—did delay first intercourse on average by nearly 18 months. However, pledging had no effect among teens who were 18 or older and also contributed to health risks for those who became sexually active.[ii]

  According to researchers Peter Bearman and Hannah Brueckner, who tracked those pledgers who had intercourse during the study period, "the estimated odds for contraceptive use for pledgers are about one-third lower than for others." The researchers noted that "pledgers are *less* likely to be prepared for an experience that they have promised to forego." They also found that "pledging does not work for adolescents at all ages" and that the efficacy of the pledge in some schools depended on its being uncommon: "Once the pledge becomes normative, it ceases to have an effect." Thus "policy makers should recognize that the pledge works because not everyone is pledging."[iii]

- Another study compared an "abstinence" program with a "safer sex" program that involved 659 African-American middle-school adolescents and found that, among those who already were sexually active when the courses began, participants in the "safer sex" program reported *less*-frequent sexual intercourse and *less*-

frequent unprotected sex one year after the program. Further, when the abstinence group was compared with a control group, it reported less sexual activity at three months following the intervention, but this distinction evaporated over time.[iv]

- A study conducted by Edward J. Saunders and colleagues at the University of Iowa School of Social Work compared survey responses from participants in a comprehensive sex-education program that promoted abstinence but allowed contraceptive information with survey responses from participants in an abstinence-unless-married program. The authors found that the former program was *more* successful in imparting knowledge about AIDS and other STDs. In addition, while the authors suggested that program comparisons should be viewed cautiously because of differences in the age of the participants, the length of the programs, and a range of other variables, they noted that the program that offered contraceptive information also appeared to be *more* successful than the abstinence-unless-married program in "promoting communication between parents and youth about sex."[v]

Further, evaluations of programs that combine abstinence education with contraceptive information find that they can help delay the onset of intercourse without a concomitant concern about health risks, and that they also reduce the frequency of intercourse and the number of partners.[vi] If there are stronger approaches that further delay the onset of intercourse by the too-young, those lessons should be adapted by programs that combine abstinence education with contraceptive information – in that way such programs will cause no health harm.

Abstinence-unless-married education programs could also result in an unintended consequence – teen marriage. Students of abstinence-unless-married programs may respond to their education by marrying younger rather than abstaining longer. While no one is promoting teen marriage, this unintended consequence carries its own set of problems. Notably, early marriages are the most unstable. And, young mothers who marry are more likely to have a rapid second birth [see CLASP's "Is Teen Marriage a Solution?"].

Even in the absence of evidence that abstinence-unless-married education reduces the risk of teen pregnancy and birth, and in spite of the new research that the reduction in sexually activity is accompanied by an increase in the health risk for some, funding for this approach has expanded beyond the $50 million per year authorized in the 1996 welfare law. As of fiscal year 2002, at least $533 million will have been earmarked in federal and state funds since 1996. Two other federal sources, the Adolescent Family Life Act (AFLA) and Special Projects of Regional and National Significance-Community-Based Abstinence Education (SPRANS-CBAE) program, have made more money available. Under the SPRANS grants, MCH can by-pass states and award grants directly to local projects; grantees, however, may not provide contraceptive education, even with separate funds. The House has increased its funds for SPRANS-CBAE from

$20 to $40 million (efforts to increase it to $73 million failed); the Senate Appropriations committee would provide $30 million. Any differences will be resolved shortly in Conference.

Proponents of increased funding for SPRANS-CBAE argue that funding "parity" is needed between abstinence-unless-married education and family planning. This comparison, however, contrasts expenditures for education against costs for medical services. Thus, this is a comparison of "apples" and "oranges" and creates even greater misunderstanding in the public debate.

As part of the theme of "parity" the Administration's budget calls for an increase in SPRANS-CBAE of an additional $33 million. However, in light of the available research, this call for increased spending seems out of sync with the Administration's general budget goal regarding "Governing with Accountability". The budget specifically asserts that "The assumption that more government spending gets more results is not generally true and is seldom tested." Indeed, some other programs which have not offered evidence of success are either eliminated or level- funded. For example, the budget "eliminates the current illegitimacy reduction bonus as there is no evidence" that it works. Also level-funded are two disadvantaged-youth education programs, TRIO and Gear Up, because "as part of the President's initiative to tie budget to performance, the Administration will assess the programs' effectiveness.

The public supports abstinence education but wants contraceptive education along with it. Virtually all of the parents of 7-12th graders (97%) want their child's sexuality education program to cover abstinence, according to a national study in 2000 by the Kaiser Family Foundation[vii]. Notably, these parents also want lessons on how to use condoms (85%) and on general birth control topics (90%)[viii]. State and local surveys also have found strong support for information about both abstinence and birth control.

The Center for Law and Social Policy believes that research should inform policy; the available research points to the importance of greater flexibility in spending available funds.

Sincerely,

Jodie Levin-Epstein
Senior Policy Analyst

Attachment A

SEPARATE PROGRAM FOR ABSTINENCE EDUCATION

"SEC. 510. (a) For the purpose described in subsection (b), the Secretary shall, for fiscal year 1998 and each subsequent fiscal year, allot to each State which has transmitted an application for the fiscal year under section 505(a) an amount equal to the product of-

"(1) the amount appropriated in subsection (d) for the fiscal year; and

"(2) the percentage determined for the State under section 502(c)(1)(B)(ii).

"(b)(1) The purpose of an allotment under subsection (a) to a State is to enable the State to provide abstinence education, and at the option of the State, where appropriate, mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on those groups which are most likely to bear children out-of-wedlock.

"(2) For purposes of this section, the term 'abstinence education' means an educational or motivational program which-

"(A) has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;

"(B) teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;

"(C) teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;

"(D) teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;

"(E) teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;

"(F) teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;

"(G) teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and

"(H) teaches the importance of attaining self-sufficiency before engaging in sexual activity.

"(c)(1) Sections 503, 507, and 508 apply to allotments under subsection (a) to the same extent and in the same manner as such sections apply to allotments under section 502(c).

"(2) Sections 505 and 506 apply to allotments under subsection (a) to the extent determined by the Secretary to be appropriate.

"(d) For the purpose of allotments under subsection (a), there is appropriated, out of any money in the Treasury not otherwise appropriated, an additional $50,000,000 for each of the fiscal years 1998 through 2002. The appropriation under the preceding sentence for a fiscal year is made on October 1 of the fiscal year.".

ENDNOTES

[i] "The review examined the evidence available regarding "studies that met the following criteria: met the scientific standards requisite for inclusion in professional journals or publications; published in 1980 or later; analyzed data collected from U.S. adolescents, most of whom were 19 or younger; used a sample size of at least 100; measured the relationship between the antecedents and one or more of the following sexual behaviors: initiation of sex, frequency of sexual intercourse, number of sexual partners, use of condoms, use of any type of contraception, pregnancy, or childbearing. (Studies that measured only out-of-wedlock pregnancy or childbearing were not included.)" Douglas Kirby, Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy, (Washington, DC: National Campaign to Prevent Teen Pregnancy, 2001), pp. 35.

[ii] The highlighted Kirby report above did not include these community-based Virginity Pledge efforts.

[iii] Peter Bearman and Hannah Brueckner, "Virginity Pledges and the Transition to First Intercourse", *Pregnancy Prevention for Youth: An Interdisciplinary Newsletter,* Vol. 3, No. 2, (June 2000); also, "Virginity Pledges as they Affect the Transition to First Intercourse", *American Journal of Sociology*, Vol. 106, No. 4, (2001).

[iv] "The abstinence intervention acknowledged that condoms can reduce risks but emphasized abstinence to eliminate the risk of pregnancy and STDs, including HIV. It was designed to...strengthen behavioral beliefs supporting abstinence...The safer-sex intervention indicated that abstinence is the best choice but emphasized the importance of using condoms to reduce the risk of pregnancy and STDS, including HIV, if participants were to have sex. It was designed to...increase skills and self-efficacy regarding [the] ability to use condoms." John B. Jemmott III, Loretta Sweet Jemmott, and Geoffrey T. Fong, "Abstinence and Safer Sex HIV Risk-Reduction Interventions for African American Adolescents, A Randomized Controlled Trial", *Journal of the American Medical Association,* Vol. 279, (May 20, 1998).

[v] Edward J Saunders, et al., "Evaluation of Abstinence-Only Education: Year One Report", *University of Iowa School of Social Work*, (October 1999).

[vi] Douglas Kirby, Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy, (Washington, DC: National Campaign to Prevent Teen Pregnancy, 2001); Douglas Kirby, No Easy Answers: Research Findings on Programs to Reduce Pregnancy, (Washington, DC: National Campaign to Prevent Teen Pregnancy, March 1997).

[vii] "Sex Education in America: A View from Inside the Nation's Classrooms", *A Series of National Surveys of Students, Parents, Teachers, and Principals,* Kaiser Family Foundation Website, (September 26, 2000), (Accessed November 6, 2001), Available online: http://www.kff.org/content/2000/3048/Chartpack.pdf.

[viii] Ibid.

Key Issue: Family

The Effectiveness of Abstinence Education Programs in Reducing Sexual Activity Among Youth

by Robert Rector

The Heritage Foundation Backgrounder

Link to: | PDF (517K) | **No. 1533** **April 8, 2002**

Teenage sexual activity is a major problem confronting the nation and has led to a rising incidence of sexually transmitted diseases (STDs), emotional and psychological injuries, and out-of-wedlock childbearing. Abstinence education programs for youth have been proven to be effective in reducing early sexual activity. Abstinence programs also can provide the foundation for personal responsibility and enduring marital commitment. Therefore, they are vitally important to efforts aimed at reducing out-of-wedlock childbearing among young adult women, improving child well-being, and increasing adult happiness over the long term.

Produced by the Domestic Policy Studies Department

Published by The Heritage Foundation 214 Massachusetts Ave., N.E. Washington, D.C. 20002-4999 (202) 546-4400 ***http://www.heritage.org***

Washington policymakers should be aware of the consequences of early sexual activity, the undesirable contents of conventional "safe sex" education programs, and the findings of the professional literature concerning the effectiveness of genuine abstinence programs. In particular, policymakers should understand that:

- **Sexually transmitted diseases (STDs), including incurable viral infections, have reached epidemic proportions.** Annually, 3 million teenagers contract STDs; STDs afflict roughly one in four teens who are sexually active.
- **Early sexual activity has multiple negative consequences for young people.** Research shows that young people who become sexually active are not only vulnerable to STDs, but also likely to experience emotional and psychological injuries, subsequent marital difficulties, and involvement in other high-risk behaviors.
- **Conventional "safe sex" programs (sometimes erroneously called "abstinence plus" programs) place little or no emphasis on encouraging young people to abstain from early sexual activity.** Instead, such programs strongly promote condom use and implicitly condone sexual activity among teens. Nearly all such programs contain
material and messages that would be alarming and offensive to the overwhelming

majority of parents.

- **Despite claims to the contrary, there are 10 scientific evaluations showing that real abstinence programs can be highly effective in reducing early sexual activity.** Moreover, real abstinence education is a fairly young field; thus, the number of evaluations of abstinence programs at present is somewhat limited. In the near future, many additional evaluations that demonstrate the effectiveness of abstinence education will become available.

Consequences of Early Sexual Activity

Young people who become sexually active enter an arena of high-risk behavior that leads to physical and emotional damage. Each year, influenced by a combination of a youthful assumption of invincibility and a lack of guidance (or misguidance and misleading information), millions of teens ignore those risks and suffer the consequences.

Sexually Transmitted Diseases

The nation is experiencing an epidemic of sexually transmitted diseases that is steadily expanding. In the 1960s, the beginning of the "sexual revolution," the dominant diseases related to sexual activity were syphilis and gonorrhea. Today, there are more than 20 widespread STDs, infecting an average of more than 15 million individuals each year. 1 Two-thirds of all STDs occur in people who are 25 years of age or younger. 2 Each year, 3 million teens contract an STD; overall, one-fourth of sexually active teens have been afflicted. 3

There is no cure for sexually transmitted viral diseases such as the human immunodeficiency virus (HIV) and herpes, which take their toll on people throughout life. Other common viral STDs are the Human Papillomavirus (HPV)--the leading viral STD, with 5.5 million cases reported each year, 4 and the cause of nearly all cases of cervical cancer that kill approximately 4,800 women per year 5 --and Chlamydia trachomatis, which is associated with pelvic inflammatory disease that scars the fallopian tubes and is the fastest growing cause of infertility.

Significantly, research shows that condom use offers relatively little protection (from "zero" to "some") for herpes and no protection from the deadly HPV. A review of the scientific literature reveals that, on average, condoms failed to prevent the transmission of the HIV virus--which causes the immune deficiency syndrome known as AIDS--between 15 percent and 31 percent of the time. 6 It should not be surprising, therefore, that while condom use has increased over the past 25 years, the spread of STDs has likewise continued to rise. 7

Emotional and Psychological Injury

Young people who become sexually active are vulnerable to emotional and psychological injury as well as to physical diseases. Many young girls report experiencing regret or guilt after their initial sexual experience. In the words of one psychiatrist who recalls the effects of her own sexual experimentation in her teens, "The longest-standing, deepest wound I gave myself was heartfelt; that sick, used feeling of having given a precious part of myself--my soul--to so many and for nothing, still aches. I never imagined I'd pay so dearly and for so long." 8

Sexually active youth often live with anxiety about the possibility of an unwanted pregnancy or contracting a devastating STD. Those who do become infected with a disease suffer emotional as well as physical effects. Fears regarding the course the disease are coupled with a loss of self-esteem and self-confidence. In a survey by the Medical Institute for Sexual Health, 80 percent of those who had herpes said that they felt "less confident" and "less desirable sexually." 9

In addition, early sexual activity can negatively affect the ability of young people to form stable and healthy relationships in a later marriage. Sexual relationships among teenagers are fleeting and unstable, and broken intimate relationships can have serious long-term developmental effects. A series of broken intimate relationships can undermine an individual's capacity to enter into a committed, loving marital relationship. In general, individuals who engage in premarital sexual activity are 50 percent more likely to divorce later in life than those who do not. 10 Divorce, in turn, leads to sharp reductions in adult happiness and child well-being.

Marital relationships that follow early sexual activity can also suffer from the emotional impact of infertility resulting from an STD infection, ranging from a sense of guilt to depression. In the words of one gynecologist and fertility specialist, "Infertility is so devastating, it often disorients my patients to life itself. This is more than shock or even depression. It impacts every level of their lives, including their marriage." 11

Correlation Between Sexual Activity and Other High-Risk Behaviors

Research from a variety of sources indicates a correlation between sexual activity among adolescents and teens and the likelihood of engaging in other high-risk behaviors, such as tobacco, alcohol, and illicit drug use.

A study reported in Pediatrics magazine found that sexually active boys aged 12 through 16 are four times more likely to smoke and six times more likely to use alcohol than are those who describe themselves as virgins. Among girls in this same age cohort, those who are sexually active are seven times more likely to smoke and 10 times more likely to use marijuana than are those who are virgins. 12 The report describes sexual activity as a "significant associate of other health-endangering behaviors" and notes an increasing recognition of the interrelation of risk behaviors. Research by the Alan Guttmacher Institute likewise finds a correlation between risk behaviors among adolescents and sexual activity; for example, teenagers who use alcohol, tobacco, and/or marijuana regularly are more likely to be sexually active. 13

Out-of-Wedlock Childbearing

Today, one child in three is born out of wedlock. Only 14 percent of these births occur to women under the age of 18. Most occur to women in their early twenties. 14 Thus, giving birth control to teens in high school through safe-sex programs will have little effect on out-of-wedlock childbearing.

Nearly half of the mothers who give birth outside marriage are cohabiting with the child's father at the time of birth. 15 These fathers, like the mothers, are typically in their early

twenties. Out-of-wedlock childbearing is, thus, not the result of teenagers' lack of knowledge about birth control or a lack of availability of birth control. Rather, it is part of a crisis in the relationships of young adult men and women. Out-of-wedlock childbearing, in most cases, occurs because young adult men and women are unable to develop committed, loving marital relationships. Abstinence programs, therefore, which focus on developing loving and enduring relationships and preparation for successful marriages, are an essential first step in reducing future levels of out-of-wedlock births.

The Silent Scandal: Promoting Teen Sex

With millions of dollars in sex-education programs at stake, it is not surprising that the groups that have previously dominated the arena have taken action to block the growing movement to abstinence-only education. Such organizations, including the Sexuality Information and Education Council of the United States (SEICUS), Planned Parenthood, and the National Abortion and Reproductive Rights Action League (NARAL), have been prime supporters of "safe-sex" programs for youth, which entail guidance on the use of condoms and other means of contraception while giving a condescending nod to abstinence. Clearly, the caveat that says "and if you do engage in sex, this is how you should do it" substantially weakens an admonition against early non-marital sexual activity.

Not only do such programs, by their very nature, minimize the abstinence component of sex education, but many of these programs also implicitly encourage sexual activity among the youths they teach. Guidelines developed by SEICUS, for example, include teaching children aged five through eight about masturbation and teaching youths aged 9 through 12 about alternative sexual activities such as mutual masturbation, "outercourse," and oral sex. 16 In addition, the SEICUS guidelines suggest informing youths aged 16 through 18 that sexual activity can include bathing or showering together as well as oral, vaginal, or anal intercourse, and that they can use erotic photographs, movies, or literature to enhance their sexual fantasies when alone or with a partner. Not only do such activities carry their own risks for youth, but they are also likely to increase the incidence of sexual intercourse.

In recent years, parental support for real abstinence education has grown. Because of this, many traditional safe-sex programs now take to calling themselves "abstinence plus" or "abstinence-based" education. In reality, there is little abstinence training in "abstinence-based" education. Instead, these programs are thinly disguised efforts to promote condom use. The actual content of most "abstinence plus" curricula would be alarming to most parents. For example, such programs typically have condom use exercises in which middle school students practice unrolling condoms on cucumbers or dildoes. 17

Effective Abstinence Programs

Critics of abstinence education often assert that while abstinence education that exclusively promotes abstaining from premarital sex is a good idea in theory, there is no evidence that such education can actually reduce sexual activity among young people. Such criticism is erroneous. There are currently 10 scientific evaluations (described below) that demonstrate the effectiveness of abstinence programs in altering sexual behavior. 18 Each of the programs evaluated is a real abstinence (or what is conventionally termed an "abstinence only") program; that is, the program does not provide contraceptives or encourage their use.

The abstinence programs and their evaluations are as follows:

1. **Virginity Pledge Programs.** An article in the Journal of the American Medical Association by Dr. Michael Resnick and others entitled "Protecting Adolescents From Harm: Findings from the National Longitudinal Study on Adolescent Health" shows that "abstinence pledge" programs are dramatically effective in reducing sexual activity among teenagers in grades 7 through 12. 19 Based on a large national sample of adolescents, the study concludes that "Adolescents who reported having taken a pledge to remain a virgin were at significantly lower risk of early age of sexual debut." 20

   In fact, the study found that participating in an abstinence program and taking a formal pledge of virginity were by far the most significant factors in a youth's delaying early sexual activity. The study compared students who had taken a formal pledge of virginity with students who had not taken a pledge but were otherwise identical in terms of race, income, school performance, degree of religiousness, and other social and demographic factors. Based on this analysis, the authors discovered that the level of sexual activity among students who had taken a formal pledge of virginity was one-fourth the level of that of their counterparts who had not taken a pledge. Overall, nearly 16 percent of girls and 10 percent of boys were found to have taken a virginity pledge.

2. **Not Me, Not Now.** Not Me, Not Now is a community-wide abstinence intervention targeted to 9- to 14-year-olds in Monroe County, New York, which includes the city of Rochester. The Not Me, Not Now program devised a mass communications strategy to promote the abstinence message through paid TV and radio advertising, billboards, posters distributed in schools, educational materials for parents, an interactive Web site, and educational sessions in school and community settings. The program sought to communicate five themes: raising awareness of the problem of teen pregnancy, increasing an understanding of the negative consequences of teen pregnancy, developing resistance to peer pressure, promoting parent-child communication, and promoting abstinence among teens.

   Not Me, Not Now was effective in reaching early teen listeners, with some 95 percent of the target audience within the county reporting that they had seen a Not Me, Not Now ad. During the intervention period, the program achieved a statistically significant positive shift in attitudes among pre-teens and early teens in the county. The sexual activity rate of 15-year-olds across the county (as reported in the Youth Risk Behavior Survey 21) dropped by a statistically significant amount from 46.6 percent to 31.6 percent during the intervention period. Finally, the pregnancy rate for girls aged 15 through 17 in Monroe County fell by a statistically significant amount, from 63.4 pregnancies per 1,000 girls to 49.5 pregnancies per 1,000. The teen pregnancy rate fell more rapidly in Monroe County than in comparison counties and in upstate New York in general, and the difference in the rate of decrease was statistically significant. 22

3. **Operation Keepsake.** Operation Keepsake is an abstinence program for 12- and 13-year-old children in Cleveland, Ohio. Some 77 percent of the children in the program were black or Hispanic. An evaluation of the program in 2001, involving a sample of over 800 students, found that "Operation Keepsake had a clear and sustainable impact

on...abstinence beliefs." The evaluation showed that the program reduced the rate of onset of sexual activity (loss of virginity) by roughly two-thirds relative to comparable students in control schools who did not participate in the program. In addition, the program reduced by about one-fifth the rate of current sexual activity among those with prior sexual experience. 23

4. **Abstinence by Choice.** Abstinence by Choice operates in 20 schools in the Little Rock area of Arkansas. The program targets 7th, 8th, and 9th grade students and reaches about 4,000 youths each year. A recent evaluation, involving a sample of nearly 1,000 students, shows that the program has been highly effective in changing the attitudes that are directly linked to early sexual activity. Moreover, the program reduced the sexual activity rates of girls by approximately 40 percent (from 10.2 percent to 5.9 percent) and the rate for boys by approximately 30 percent (from 22.8 percent to 15.8 percent) when compared with similar students who had not been exposed to the program. (The sexual activity rate of students in the program was compared with the rate of sexual activity among control students in the same grade in the same schools prior to the commencement of the program.) 24

5. **Virginity Pledge Movement.** A 2001 evaluation of the effectiveness of the virginity pledge movement using data from the National Longitudinal Study of Adolescent Health finds that virginity pledge programs are highly effective in helping adolescents to delay sexual activity. According to the authors of the study:

   Adolescents who pledge, controlling for all of the usual characteristics of adolescents and their social contexts that are associated with the transition to sex, are much less likely than adolescents who do not pledge, to have intercourse. The delay effect is substantial and robust. Pledging delays intercourse for a long time. 25

   The study, based on a sample of more than 5,000 students, concludes that taking a virginity pledge reduces by one-third the probability that an adolescent will begin sexual activity compared with other adolescents of the same gender and age, after controlling for a host of other factors linked to sexual activity rates such as physical maturity, parental disapproval of sexual activity, school achievement, and race. When taking a virginity pledge is combined with strong parental disapproval of sexual activity, the probability of initiation of sexual activity is reduced by 75 percent or more.

6. **Teen Aid and Sex Respect.** An evaluation of the Teen Aid and Sex Respect abstinence programs in three school districts in Utah showed that both programs were effective among the students who were at the greatest risk of initiating sexual activity. Approximately 7,000 high school and middle school students participated in the evaluation. To determine the effects of the programs, students in schools with the abstinence programs were compared with students in similar control schools within the same school district. Statistical adjustments were applied to further control for any initial differences between program participants and control students. The programs together were shown to reduce the rate of initiation of sexual activity among at-risk high school students by over a third when compared with a control group of similar students who were not exposed to the program. 26 Statistically significant changes in behavior were not found among junior high students.

   When high school and junior high school students were examined together, Sex

Respect was shown to reduce the rate of initiation of sexual activity among at-risk students by 25 percent when compared with a control group of similar students who were not exposed to the program. Teen Aid was found to reduce the initiation of sex activity by some 17 percent. A third non-abstinence program, Values and Choices, which offered non-directive or value-free instruction in sex education and decision-making, was found to have no impact on sexual behavior.

7. **Family Accountability Communicating Teen Sexuality (FACTS).** An evaluation performed for the national Title XX abstinence program examined the effectiveness of the Family Accountability Communicating Teen Sexuality abstinence program in reducing teen sexual activity. The evaluation assessed the FACTS program by comparing a sample of students who participated in the program with a group of comparable students in separate control schools who did not participate in the program. The experimental and control students together comprised a sample of 308 students. The evaluation found the FACTS program to be highly effective in delaying the onset of sexual activity. Students who participated in the program were 30 percent to 50 percent less likely to commence sexual activity than were those who did not participate. 27

8. **Postponing Sexual Involvement (PSI).** Postponing Sexual Involvement was an abstinence program developed by Grady Memorial Hospital in Atlanta, Georgia, and provided to low-income 8th grade students. A study published in Family Planning Perspectives, based on a sample of 536 low-income students, showed that the PSI program was effective in altering sexual behavior. 28 A comparison of the program participants with a control population of comparable low-income minority students who did not participate showed that PSI reduced the rate of initiation of sexual activity during the 8th grade by some 60 percent for boys and over 95 percent for girls. 29 As the study explained:

   The program had a pronounced effect on the behavior of both boys and girls who had not been sexually involved before the program.... By the end of eighth grade, boys who had not had the program were more than three times as likely to have begun having sex as were boys who had the program.... Girls who had not had the program were as much as 15 times more likely to have begun having sex as were girls who had had the program. 30

   The effects of the program lasted into the next school year even though no additional sessions were provided. By the end of the 9th grade, boys and girls who had participated in PSI were still some 35 percent less likely to have commenced sexual activity than were those who had not participated in the abstinence program. 31

9. **Project Taking Charge.** Project Taking Charge is a six-week abstinence curriculum delivered in home economics classes during the school year. It was designed for use in low-income communities with high rates of teen pregnancy. The curriculum contains these elements: self-development; basic information about sexual biology (anatomy, physiology, and pregnancy); vocational goal-setting; family communication; and values instruction on the importance of delaying sexual activity until marriage. The effect of the program has been evaluated in two sites: Wilmington, Delaware, and West Point, Mississippi. The evaluation was based on a small sample of 91 adolescents. Control and experimental groups were created by randomly assigning classrooms to either receive or not receive the program. The students were assessed

immediately before and after the program and through a six-month follow-up.

In the six-month follow-up, Project Taking Charge was shown to have had a statistically significant effect in increasing adolescents' knowledge of the problems associated with teen pregnancy, the problems of sexually transmitted diseases, and reproductive biology. The program was also shown to reduce the rate of onset of sexual activity by 50 percent relative to the students in the control group, although the authors urge caution in the interpretation of these numbers due to the small size of the evaluation sample. 32

10. **Teen Aid Family Life Education Project.** The Teen Aid Family Life Education Project is a widely used abstinence education program for high school and junior high students. An evaluation of the effectiveness of Teen Aid, involving a sample of over 1,300 students, was performed in 21 schools in California, Idaho, Oregon, Mississippi, Utah, and Washington. The Teen Aid program was shown to have a statistically significant effect in reducing the rate of initiation of sexual activity (loss of virginity) among high-risk high school students, compared with similar students in control schools. Among at-risk high school students who participated in the program, the rate of initiation of sexual activity was cut by more than one-fourth, from 37 percent to 27 percent. A similar pattern of reduction was found among at-risk junior high school students, but the effects did not achieve statistical significance. The program did not have statistically significant effects among lower-risk students. 33

Conclusion

Real abstinence education is essential to reducing out-of-wedlock childbearing, preventing sexually transmitted diseases, and improving emotional and physical well-being among the nation's youth. True abstinence education programs help young people to develop an understanding of commitment, fidelity, and intimacy that will serve them well as the foundations of healthy marital life in the future.

Abstinence education programs have repeatedly been shown to be effective in reducing sexual activity among their participants. However, funding for the evaluation of abstinence education programs until very recently has ranged from meager to nonexistent. Currently, the number of adequately funded evaluations of abstinence education is increasing. At present, there are several promising new evaluation nearing completion. As each year passes, it can be expected that the number of evaluations showing that abstinence education does significantly reduce sexual activity will grow steadily.

Abstinence education is a nascent and developing field. Substantial funding for abstinence education became available only within the past few years. As abstinence programs develop and become more broadly available, future evaluations will enable the programs to hone and increase their effectiveness.

-Robert Rector is Senior Research Fellow in Domestic and Economic Policy Studies at The Heritage Foundation.

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2. American Social Health Association, at http://www.ashastd.org/stdfaqs/statistics.html.

3. Alan Guttmacher Institute, Sex and America's Teenagers (New York: Alan Guttmacher Institute, 1994), pp. 19-20.

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5. American Cancer Society, Cancer Facts and Figures, 1998, at http://www.cancer.org.

6. Dr. Susan Weller, "A Meta-Analysis of Condom Effectiveness in Reducing Sexually Transmitted HIV," Social Science and Medicine, Vol. 36, No. 12 (1993). See also National Institute of Allergy and Infectious Diseases, National Institutes of Health, Department of Health and Human Services, "Summary," Scientific Evidence on Condom Effectiveness for Sexually Transmitted Disease (STD) Prevention, July 20, 2001, at http://www.niaid.nih.gov/dmid/stds/condomreport.pdf.

7. Centers for Disease Control and Prevention, Tracking the Hidden Epidemics 2000: Trends in STDs in the United States, 2000, at http://www.cdc.gov/nchstp/od/news/RevBrochure1pdftoc.htm.

8. Tom and Judy Lickona, with William Boudreau, M.D., Sex, Love and You (Notre Dame, Ind.: Ave Maria Press, 1994), p. 70.

9. Medical Institute for Sexual Health, "Safe Sex," lecture with slide show, Austin, Texas, 1992.

10. Joan R. Kahn and Kathryn A. London, "Premarital Sex and the Risk of Divorce," Journal of Marriag and the Family, November 1991, pp. 845-855.

11. Joe S. McIlhaney, M.D., Why Condoms Aren't Safe (Colorado Springs, Colo.: Focus on the Family, 1993).

12. D. P. Orr, M. Beiter, and G. Ingersoll, "Premature Sexual Activity as an Indicator of Psychosocial Risk," Pediatrics, Vol. 87, No. 2 (February 1, 1991), pp. 141-147. See also Kimberly Erickson, "Interconnections: Emerging Patterns in Youth Risk Behavior," Institute for Youth Development, Washington, D.C., June 1, 1998.

13. Alan Guttmacher Institute, Sex and America's Teenagers.

14. See, for example, U.S. Department of Health and Human Services, National Center for Health Statistics, "National Vital Statistics Report," 2001.

15. Irwin Garfinkle and Sara McLanahan, The Fragile Families and Child Wellbeing Study, baseline report, at http://crcw.princeton.edu/fragilefamilies/nationalreport.pdf.

16. SIECUS National Guidelines for Comprehensive Sexuality Education Kindergarten--12th Grade, an National Guidelines Task Force, The Sexuality Information and Education Council of the United States (SEICUS), 1992.

17. Major programs with this type of activity include "Focus on Kids," "Becoming a Responsible Teen," and "Be Proud! Be Responsible!"

18. Most of the programs in this section show reductions in sexual activity that are statistically significa

at the 95 percent confidence level and above. The significance of these studies is indisputable. In addition, a few studies show programs with positive effects in reducing sexual activity, but with statistic significance levels in the 90 percent to 94 percent confidence range. Because they fall short of the 95 percent confidence level, each of these studies viewed in isolation might be dismissed as inconclusive. Yet, viewed in conjunction with each other, the existence of multiple studies based on small samples, each showing the positive effects of abstinence programs in reducing sexual activity with tests of statistical significance slightly below the 95 percent confidence level, offers evidence reinforcing the cas for the overall effectiveness of abstinence education.

19. Michael Resnick, M.D., et al., "Protecting Adolescents from Harm: Findings from the National Longitudinal Study on Adolescent Health," Journal of the American Medical Association, Vol. 278 (September 10, 1997). The effects of a virginity pledge in reducing sexual activity were statistically significant at the 99.9 percent confidence level.

20. Ibid., p. 830.

21. L. Kahn et al., "Youth Risk Behavior Survey--United States 1997," Morbidity and Mortality Weekly Reports, Vol. 47 (SS-3), 1998, pp. 1-89.

22. Andrew S. Doniger, "Impact Evaluation of the 'Not Me, Not Now' Abstinence-Oriented, Adolescent Pregnancy Prevention Communications Program, Monroe County, New York," Journal of Health Communications, Vol. 6 (2001), pp. 45-60. Both the shifts in attitudes and the decline in sexual activity rate over the intervention period were statistically significant at the 95 percent confidence level. The difference in the rate of decline in adolescent pregnancy in Monroe County, when compared to other geographic areas, was statistically significant at the 95 percent to 99 percent confidence levels.

23. Elaine Borawski et al., Evaluation of the Teen Pregnancy Prevention Programs Funded through the Wellness Block Grant (1999-2000), Center for Health Promotion Research, Department of Epidemiolog and Biostatistics, Case Western Reserve University, School of Medicine, March 23, 2001. The program effects on sexual activity were significant at the 93 percent confidence level.

24. Stan E. Weed, Title V Abstinence Education Programs: Phase I Interim Evaluation Report to Arkansas Department of Health, Institute for Research and Evaluation, October 15, 2001. The effects of the program in reducing the onset of sexual activity were statistically significant at the 98 percent confidence level. (Data on statistical significance are not currently included in the written report but wer provided separately to the author by the evaluator, Dr. Stan Weed.)

25. Peter S. Bearman and Hanna Bruckner, "Promising the Future: Virginity Pledges and First Intercourse," American Journal of Sociology, Vol. 106, No. 4 (January 2001), pp. 861, 862. The effects a virginity pledge were shown to be statistically significant at the 95 percent confidence level.

26. Stan E. Weed, Predicting and Changing Teen Sexual Activity Rates: A Comparison of Three Title XX Programs, report submitted to the Office of Adolescent Pregnancy Programs, U.S. Department of Health and Human Services, December 1992. The effects the programs on at-risk high school students were significant at the 99 percent confidence level.

27. Stan E. Weed, FACTS Project: Year End Evaluation Report, 1993-1994, prepared for the Office of Adolescent Pregnancy Prevention Programs.

28. Marion Howard and Judith Blarney McCabe, "Helping Teenagers Postpone Sexual Involvement,"

Family Planning Perspectives, January/February 1990, pp. 21-26.

29. These effects were statistically significant at the 99 percent confidence level.

30. Howard and McCabe, "Helping Teenagers Postpone Sexual Involvement," p. 24.

31. These effects were statistically significant at the 95 percent confidence level.

32. Stephen R. Jorgensen, Vicki Potts, and Brian Camp, "Project Taking Charge: Six-Month Follow-Up of a Pregnancy Prevention Program for Early Adolescents," Family Relations, October 1993, pp. 401-406. The effects of the program in reducing the rate of onset of sexual activity were statistically significant at the 94.9 percent confidence level. The effects of the program on specific areas of knowled were significant at the 95 percent confidence level and above.

33. Stan E. Weed, Jerry Prigmore, and Raja Tanas, The Teen Aid Family Life Education Project: Fifth Year Evaluation Report, Institute for Research and Evaluation, 1992. The effect of the program on the sexual activity of high-risk high school students was statistically significant at the 99 percent confidence level.

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Ms. Barbara Kristin Hoover
1393 Lenape Road
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Dear Ms. Hoover:

Thank you for contacting me to express your support for H.R. 2037, the Protection of Lawful Commerce in Arms Act, and for gun control legislation. It was good to hear from you.

As you may know, H.R. 2037 was introduced by Rep. Cliff Stearns on May 25. This bill would prevent costly and frivolous lawsuits against the firearms industry with the intent to regulate business practices. Specifically, H.R. 2037 states that lawful conduct by a firearms manufacturer or seller cannot be a basis for civil liability if another person unlawfully used their product.

Like you, I believe that criminal activity will not be reduced by restricting the Constitutional right of law-abiding adult citizens to own guns. As a cosponsor of H.R. 2037, I believe that such proposals, like many efforts to restrict our freedoms, are well-intentioned, but misguided and often counterproductive. Rest assured, I will continue to monitor this bill as it moves through the legislative process.

Regarding gun control legislation, some believe that passing new laws will keep tragedies such as school shootings from happening. I, however, am concerned that many current gun laws are not being enforced. The shooters in all of these cases broke numerous local, state and federal laws, yet the killings were not prevented.

Ultimately, this is not only a gun problem; this is a cultural problem. More gun laws will not teach our children the difference between right and wrong, or to respect their classmates and neighbors, or that violence is not the norm. We must help parents raise good children. We must reinforce character, respect, and the moral guideposts in society that our children need to develop a proper sense of right and wrong.

The Second Amendment of the U.S. Constitution reads, "the right of the people to keep and bear arms, shall not be infringed." While some may disagree, I firmly believe that plain language of this Amendment guarantees the right of law-abiding citizens to keep and bear arms of their choice. If we are to honor and uphold our Constitution, this right cannot be infringed.

Thanks for sharing your views with me. Please don't hesitate to contact me in the future on any issue that concerns you or your family.

Cordially,

Joseph R. Pitts
Member of Congress

TITLE V | ABSTINENCE EDUCATION EVALUATION

AOE-1300

April 25, 2002

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Dear Mr. Chairman:

As the senior investigators for the independent evaluation of abstinence education programs funded under Title V Section 510, we feel compelled to clarify the key findings from the report *The Evaluation of Abstinence Education Programs Funded Under Title V, Section 510: Interim Report* (April 2002).

Contrary to reports in the press and by some participants in your committee's hearings, our research does NOT suggest that the Title V Section 510 program should be abolished or significantly altered. The current research base does NOT indicate that abstinence programs are ineffective.

Our research does show that the majority of the Title V Section 510 programs offer much more than "Just Say No." In addition to delivering a clear and consistent message of abstinence until marriage, program components focus on building self-esteem, developing values, formulating goals, making decisions, avoiding risky behavior, maximizing communication, strengthening relationships, understanding sexually transmitted diseases, withstanding social and peer pressures, maintaining self-control, aspiring to marriage, and understanding parenthood.

Over the past decade, we have seen an increase in the role of abstinence education as a strategy for preventing teen pregnancy and sexually transmitted diseases. As the evaluation continues and the data collection is completed, the study will provide scientifically rigorous evidence on the effects of Title V Section 510 abstinence education programs.

Sincerely,

Rebecca Maynard Barbara Devaney

cc: Meredith Kelsey, U.S. Department of Health and Human Services